UNIVERSITY OF

LOUISVILLE®

DEPARTMENT OF FAMILY AND GERIATRIC MEDICINE

RESIDENCY POLICY MANUAL

Revised July 1, 2013

It's Happening Here.

1.0 GENERAL INFORMATION

1.1 Purpose

The purpose of this document is to provide faculty, residents, and staff with easy access to the policy of the U of L Family Medicine Residency Program.

The address for the program is:

U of L Family Medicine
201 Abraham Flexner Way, Ste. 690
Louisville KY 40202

The program's phone number is 852-5499.
The program's fax number is 852-4944.

1.2 Locker

There is a locker for every resident in the Residents' Lounge for personal items. A $20 cash deposit is required for a key to a locker. This will be returned at the end of residency once the key is returned.

1.3 Mail

Every resident is provided with an Outlook email account and a mailbox in the Residents' Lounge. All information concerning the resident's rotations, schedules of Family Medicine Office responsibilities and call schedules will be distributed via these email accounts and/or mailboxes. Any mail posted through the University of Louisville postal system will also be distributed to the resident via the mailbox. This will include, but is not limited to, licensing matters and house staff policies and procedures. Each resident will be assigned a mail tray in their respective office site for clinic and patient related matters.

Most of the communication within the Department of Family and Geriatric Medicine is handled via email and every resident is provided with a user ID and access to systems in their offices and in the lounge in the program office. Independent email service providers, such as Hotmail and Yahoo, will not accept files as large as the clinic schedules; therefore all residents must activate and use the University-provided Outlook account. All residency, departmental, and university information is to be handled through individual Outlook accounts not personal accounts.

Certain emails, including but not limited to office schedules, ACGME surveys, and rotation and license information, will be sent with "Reply Necessary" in the subject line. When you receive such an email, you must:

1. Complete the specified tasks (review the schedule, complete the task, provide the information, turn in the form, etc.)
2. Reply to Tanya Keenan within 14 days (unless a different deadline is given) with specific feedback regarding your completion of the task.

We will track your responses as one indication of your growth in the core competencies of Professionalism ("commitment to carrying out professional responsibilities"), Interpersonal and Communication Skills ("effective information exchange and teaming"), Practice-based Learning and Improvement ("improvements in patient care" by minimizing late recognition of conflicts and subsequent rescheduling of patients) and Systems-Based Practice ("effectively calling on system resources to provide care that is of optimal value").

2.0 RESIDENCY EDUCATIONAL GOALS AND OBJECTIVES

2.1 Overall Residency Program Goals

The Family Medicine Residency Program at the University of Louisville School of Medicine is committed to the following goals:

- To train and develop outstanding physicians who have excellent clinical and communication skills.
- To encourage personal growth and develop doctors with humanitarian and leadership qualities who are active in their communities.
- To understand the diverse communities in which we work and practice, and develop the attitudes and skills necessary to deliver quality care to these populations.
- To emphasize patient dignity, to enhance the patient-physician relationship, and to include patients as partners in their care.
- To educate family physicians within a broad scope of practice enabling them to provide care throughout the life cycle.
- To help physicians easily access and navigate electronic medical references for practice guidelines, for answers to clinical inquiries, and for the latest evidence-based medicine.
- To educate family physicians in the proper use of consultants and to coordinate services for integrated patient care.
- To fully integrate family physicians into multi-disciplinary health care teams.
- To teach physicians how to practice medicine efficiently in preparation for future practice, including office management, reimbursement, use of electronic health record, and teamwork.
- To teach learners how to become teachers, how to best educate their colleagues and patients, and the art of giving and receiving constructive feedback.
- To prepare physicians to become lifelong learners.

2.2 Relative to ACGME Core Competencies

During and upon completion of the three years of Family Medicine training, it is the Residency Program's goal to ensure and certify that the resident has attained "competent" skills within the context of the six areas listed below. Toward this end, the Accreditation Council for Graduate Medical Education (ACGME) and the Program defines the specific knowledge, skills, and attitudes required and provides educational experiences needed for residents to demonstrate competency in:

1. **Patient Care (PC)** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

2. **Medical Knowledge (MK)** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

3. **Practice-Based Learning and Improvement (PBL)** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvement in patient care.

4. **Interpersonal and Communication Skills (ICS)** that result in effective information exchange and teaming with patients, their families, and other health professionals.

5. **Professionalism (P)**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. **Systems-Based Practice (SBP)**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

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2.3 EDUCATIONAL OBJECTIVES AND PROMOTION OBJECTIVES FOR CRITERIA FOR EACH PGY

2.3.1 PGY1 Educational Objectives

The PGY1 resident must satisfactorily complete:

- 12 blocks = 12 month long rotations
  - Before receiving a passing grade for a rotation residents must complete an on-line evaluation of that rotation.
- Attendance at approved educational activities per Policy Manual.
- Appropriate progress in attaining the appropriate clinical skills commiserate with level of training. This includes but is not limited to:

1. Acceptable progress as determined by the Family Medicine Residency Promotion Committee.
2. A minimum of 150 continuity patient encounters.
3. Successfully completing and passing USMLE Step 3.
4. Obtaining a valid Kentucky medical license, per Policy Manual.
5. Satisfactory completion of the following educational objectives:
   a. Identifies purpose of visit **(PC, MK)**
   b. Gathers complete and reliable history **(PC, MK)**
   c. Develops an appropriately ordered, reasonable differential diagnosis for presenting problem **(PC, MK, PBL)**
   d. Orders appropriate labs/tests for the presenting problem **(PC, MK, PBL)**
   e. Presents working diagnosis to patient and/or family **(PC, MK, IPC)**
   f. Discusses appropriate follow-up and/or discharge planning **(PC, IPC, P, SBP)**
   g. Prescribes medications appropriately **(PC, MK)**
   h. Considers the ramifications of treatment (meds, IV fluids, radiologic studies, etc.) including interactions, side effects, and potential complications **(PC, MK, SPB)**
   i. Educates patient about prescribed medications **(IPC, P, SBP)**
   j. Documentation entered into the electronic health record (EHR) chart at the clinic sites and paper charts in the hospitals in a timely fashion. The information is concise, in SOAP format, legible (in paper chart), and contains a completed problem list for each patient **(P, IPC, P, SBP)**
   k. Maintains all charting information including but not limited to medicine/allergy list and problem list as well as completes all assigned EHR tasks **(IPC, P, PBL, SBP)**
   l. Demonstrates a commitment to carrying out professional responsibilities **(P)**
   m. Billing for patient care appropriately **(SBP)**
   n. Performs hospital duties with appropriate guidance and independence **(PC, MK, P, SBP)**
   o. Recognizes limitations and seeks help appropriately **(P)**
   p. Accepts feedback **(P)**
   q. Uses instructional technology to determine best medical evidence **(SBP)**
   r. Introduces self to patient and addresses patient with appropriate title **(P)**
   s. Becomes competent in all First Year Resident Physical Exam skills **(PC, MK)**
   t. Demonstrates sensitivity to a diverse patient population **(IPC, P)**
   u. Documents all procedures performed during PGY1 **(P, SBP)**
   v. Begin to evaluate the literature for patient care/presentations **(PBL, SBP)**
   w. Receives a passing evaluation and feedback for each rotation during PGY1 **(PC, MK, PBL, P)**
   x. Adheres to all duty hour requirements **(P)**

y. Meets expected behaviors and knows content identified in Policy Manual **(P)**

A resident will not be promoted to the PGY2 level if any of the following is in evidence.

1. Performance on any of the 12 block rotations is deemed unsatisfactory.*
2. Failure of complying with the above guidelines.
3. Failure to complete and pass USMLE Step 3.
4. Failure to obtain a valid license to practice medicine in the state of Kentucky.
5. Unacceptable care rendered to patients of the Family Medicine Offices.
6. Failure to provide documentation for a sufficient number of OB deliveries.
7. Failure to complete a minimum of 150 continuity patient encounters.
8. Accumulated absences in excess of 30 days.

** Those rotations in which performance was deemed unsatisfactory must be successfully repeated as a PGY1 with a satisfactory performance. An elective month may be used to remediate a rotation that has been deemed unsatisfactory. Only one elective month may be used to remediate a rotation throughout the residency. Any other remediation months will be added to residency training length.*

Those PGY1s who fail to meet the promotion criteria will be placed on academic warning (a maximum of three months) and kept at the PGY1 level until skills are commensurate with those expected of a PGY2. Failure at the end of the academic warning period may result in a probationary period and possible future dismissal from the program.

2.3.2 PGY2 Educational Objectives

The PGY2 resident must satisfactorily complete:

- 12 blocks = 12 month long rotations (Night Float is considered the 13th month long rotation)
  - Before receiving a passing grade for a rotation residents must complete an on-line evaluation of that rotation.
- Attendance at approved educational activities per Policy Manual
- Appropriate progress in attaining clinical skills commiserate with level of training. This includes but is not limited to:

1. Acceptable progress as determined by the Family Medicine Residency Promotion Committee.
2. Acceptable care of at least two continuity nursing home patients during PGY2 and PGY3.
3. A minimum of 500 continuity patient encounters.
4. Satisfactory completion of the following educational objectives:
   a. Implements a negotiated management plan with patient and/or family **(PC, MK, PBL, ICS)**
   b. Addresses sensitive issues appropriately such as mental health or risk behaviors **(ICS, P)**
   c. Addresses chronic problems when appropriate (**PC, MK, ICS, SBP)**
   d. Incorporates health maintenance and preventative care where appropriate **(PB, MK, PBL, SBP)**
   e. Arranges appropriate medical and ancillary referrals **(PBL, ICS, SBP)**
   f. Manages clinic duties efficiently **(PBL, ICS, P, SBP)**
   g. Discusses end-of-life issues appropriately and in a sensitive way with patients **(PB, ICS, P)**
   h. Acts with increasing independence on FMHS **(PC, MK, P, SBP)**

i. Responds appropriately in emergent/urgent situations **(PC, MK, P)**

j. Teaches students and interns in clinic and/or on hospital service **(ICS, P)**
k. Begins/completes home visits, nutrition consults, and mental health requirements **(PC, MK, PBL, ICS, P, SBP)**
l. Works with non-physician professionals in a way that garners mutual respect and excellent patient care **(ICS, P, SBP)**
m. Documents all procedures performed during PGY2 **(P)**
n. Receives a passing evaluation and feedback for each outside rotation during PGY2 **(P)**
o. Misses no more than 10 excused Core Conference absences and attends 80% of Grand Rounds **(PC, MK, P)**
p. Meets expected behaviors and knows content identified in updated/revised Policy Manual **(P)**
q. Critically evaluates literature for patient care/presentations **(PC, MK, PBL, ICS, P)**
r. Documentation entered into the electronic health record (EHR) chart at the clinic sites and paper charts in the hospitals in a timely fashion. The information is concise, in SOAP format, legible (in paper chart), and contains a completed problem list for each patient **(P, IPC, P, SBP)**
s. Maintains all charting information including but not limited to medicine/allergy list and problem list as well as completes all assigned EHR tasks **(IPC, P, PBL, SBP)**

A resident will not be promoted to the PGY3 level if any of the following is in evidence.

1. Performance on any of the 12 block rotations is deemed unsatisfactory.*
2. Loss of Licensure.
3. Failure to complete a minimum of 500 continuity patient encounters.
4. Unacceptable care rendered to patients of the Family Medicine Centers and/or the nursing home.
5. Accumulated absences in excess of 30 days.

** Those rotations in which performance was deemed unsatisfactory must be successfully repeated as a PGY2 with a satisfactory performance. An elective month may be used to remediate a rotation that has been deemed unsatisfactory. Only one elective month may be used to remediate a rotation throughout the residency. Any other remediation months will be added to residency training length.*

Those PGY2s who fail to meet the promotion criteria will be placed on academic warning (a maximum of three months) and kept at the PGY2 level until skills are commensurate with those expected of a PGY3. Failure at the end of the academic warning period may result in a probationary period and possible future dismissal from the program.

2.3.3 PGY3 Educational Objectives

The PGY3 resident must satisfactorily complete:

- 12 blocks = 12 month long rotations (Night Float is considered the 13th month long rotation)
    - Before receiving a passing grade for a rotation residents must complete an on-line evaluation of that rotation.
- Attendance at approved educational activities per Policy Manual
- Appropriate progress in attaining clinical skills commiserate with level of training. This includes but is not limited to:

1. Acceptable work as determined by the Family Medicine Residency Promotion Committee
2. Fulfill the requirements set forth in the ACGME "Common Program Requirements," and the "Family Medicine Program Requirements" as well as the "Requirements for Certification by the American Board of Family Medicine."
3. Complete prior to the end of the PGY3 all longitudinal experiences which will include:
    a. Acceptable work determined by Family Medicine Residency Promotion Committee.
    b. A minimum of 1650 continuity patient encounters over the three years of residency.
    c. Acceptable care of at least two continuity nursing home patients during PGY2 and PGY3.
    d. Documentation of care of at least 15 ICU patients
    e. Documentation of at least two home visits, one being a geriatric patient **(THIS IS TO BE DONE PRIOR TO JANUARY 1ST OF PGY3 OR THE FIRST DAY OF BEGINNING OF THE RESIDENTS LAST SIX MONTHS IN RESIDENCY)**.
    f. Nutrition requirement – refer at least three (3) patients with nutrition concerns during 3-year residency, per Policy Manual.
    g. Fulfillment of the research requirement, per Policy Manual.
    h. Completion of Mental/Behavioral Health longitudinal rotation.
    i. Completing of Community Health longitudinal rotation.
    j. Documentation of at least 40 OB deliveries; 30 during OB rotations and 10 longitudinal deliveries (natal, antenatal, and postnatal) of Family Medicine patients.

4. Complete the following educational objectives:
    a. Works with patient and family to develop a collaborative relationship and management plan that includes care of acute and chronic issues, health maintenance, disease prevention, and continuity of care **(PC, MK, PBL, ICS)**
    b. Works with and motivates all staff in a way that garners mutual respect and efficient patient care **(PC, PBL, ICS, P, SBP)**
    c. Actively manages clinic time **(PB, PBL, P, SBP)**
    d. Able to function as a "Teaching Senior Resident" in clinic and on FMHS **(PC, MK, ICS, P)**
    e. Documentation entered into the electronic health record (EHR) chart at the clinic sites and paper charts in the hospitals in a timely fashion. The information is concise, in SOAP format, legible (in paper chart), and contains a completed problem list for each patient **(P, IPC, P, SBP)**
    f. Maintains all charting information including but not limited to medicine/allergy list and problem list as well as completes all assigned EHR tasks **(IPC, P, PBL, SBP)**
    g. Prescribes medication and orders tests/ancillary services that are cost effective and appropriate for patient's needs and resources **(PC, MK, PBL, ICS, P, SBP)**
    h. Resident is seen as an advocate for the FMC and as such encourages patients to choose him/her and the clinic for their ongoing care **(PBL, ICS, P, SBP)**
    i. Works with physician colleagues in a way that garners mutual respect and excellent patient care **(ICS, P)**
    j. Documents all procedures performed during PGY3 **(P)**
    k. Receives an evaluation and feedback for each outside rotation during PGY3 **(P)**
    l. Meets expected behaviors and knows content identified in Policy Manual **(P)**
    m. Critically evaluates literature for patient care/presentation **(PC, MK, PBL, ICS)**
    n. Meets all six core competency requirements and receives documentation to verify accomplishment **(PC, MK, PBL, ICS, P, SBP)**
    o. The graduating resident must demonstrate sufficient competence to enter practice without direct supervision **(PC, MK, PBL, ICS, P, SBP)**

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3.0 RESIDENCY PROGRAM RULES, REGULATIONS, POLICIES AND BENEFITS

3.1 Core Conference and Grand Rounds Attendance Policy

1. Attendance at Core Conferences and Grand Rounds is an expectation for all residents. These venues serve to further the education of all residents. Failure to attend conferences conveys disrespect to the presenters and a lack of professionalism.

2. Attendance for Core Conference (inclusive of site meetings) and Grand Rounds are counted by days attended.

3. PGY1
    a. Residents must attend 65% of the Core Conferences yearly,
    b. Residents must attend 80% of Grand Rounds Yearly.

4. PGY 2 and 3
    a. Residents are allowed 10 excused absences for Core Conferences yearly.
        1. Excused absences include: vacation, OB nights, hospital service, night float, CME, and two additional days.
    b. Residents must attend 80% of Grand Rounds yearly.

5. Residents must sign in at Core Conference by 1:15 and stay until 5:00 to get credit for the day. Residents must sing in for Grand Rounds by 7:45 and stay until 8:30 to get credit for the conference.

6. Residents may make up one unexcused absence for Core Conference yearly. This may be done by attending 2 Geriatric or 4 Sports Medicine Conferences.

7. Consequences for not complying with attendance rules include but are not limited to:
    a. Not receiving CME money.
    b. The Department not paying for Board exam fees.
    c. Academic warning to be determined by the Residency Promotion Committee.

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3.2 Departmental Requirements for PGY3's to Sit for the American Board of Family Medicine Certification Examination:

1. Fulfill the requirements set forth in the ACGME "Common Program Requirements", (http://acgme.org/acgmeweb/Portals/0/dh_dutyhoursCommonPR07012007.pdf), the "Family Medicine Program Requirements", (http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/120pr07012007.pdf), and the "Requirements for Certification by the American Board of Family Medicine", **(Section 5.0)**.
2. Satisfactory completion of all longitudinal experiences by the end of PGY3, which will include:
   a. Acceptable work determined by Family Practice faculty.
   b. A minimum of 1650 continuity patient encounters.
   c. Acceptable attendance hours at the Family Medicine Core Conferences and Departmental Grand Rounds
   d. Fulfillment of the research requirement:
      i. Prior to submission to the program director, the written report must be read, signed and dated by the faculty advisor, co-author, or research director. Residents whose last rotation month is June-December must turn in their written report and make their poster presentation by March of the same year. Poster presentations will be done in Grand Rounds. Residents whose last rotation month is January-May may elect to turn in their written report and make their poster presentation in March of the prior year, but must complete this requirement at least 3 months prior to residency completion.
   e. Acceptable care of nursing home patients and documentation of all nursing home visits.
   f. Documentation of a minimum of two home visits from the resident's panel of patients, one being a geriatric patient. Documentation of 40 OB deliveries; 30 during OB rotations and 10 longitudinal (natal, antenatal, and postnatal deliveries of Family Medicine patients.)
   g. Documentation of a minimum of care of 15 ICU patients.
   h. Completion of Community Medicine longitudinal rotation.
   i. Supervision of procedures:
      1 All procedures performed by family practice residents must be under the supervision of an attending physician,
      2 Residents who prove proficiency at basic procedures may be judged by faculty attending physicians to be competent in that procedure and may perform it without the direct supervision of an attending. However, prior to the procedure the resident must obtain consent to proceed from the attending and must be document this in the note,
      3 Residents must maintain an up-to-date log of such procedures and regularly submit this log to the residency office. The log entry for each procedure must contain the name and medical record number of the patient, name of the supervising attending physician and a description of the procedure. The date of the procedure and a comment about the degree of participation and the proficiency of the resident must also be included. Competency in such procedures will be determined by review of the resident procedure logs by the residency director. When a resident is judged by faculty to be independently competent in a procedure, the residency director will inform the office of Graduate Medical Education and the Hospital staff office.

Procedural Competencies for University of Louisville Family Medicine Residency*			
	A0: All residents must be able to perform but documentation not required	**A1: All residents must be able to perform independently by graduation. These have to be documented.**	**A2: All residents must be exposed to and have the opportunity to train to independent performance. These have to be documented.**
Skin	Remove corn/callous Drain subungual hematoma Fungal studies (KOH) Establishing and maintaining appropriate sterile technique	Biopsies - Punch, excisional, and incisional Cryosurgery Remove warts, fingernail, toenail, foreign body Incision and drainage of abscess Simple laceration repair with sutures Skin tag removal	
Maternity care		Spontaneous vaginal delivery, including: - Fetal monitoring - Fetal scalp electrode - Labor induction/augmentation - First- and second-degree laceration repair NST/CST interpretation	OB ultrasound interpretation Third- and fourth-degree laceration repair Manual extraction of placenta
Women's health	Pap smear Wet mount, KOH	Endometrial biopsy IUD insertion/removal Implantable subdermal contraceptive device insertion/removal	Colposcopy
Life support courses	EKG interpretation	ACLS	NRP, PALS, ALSO, ATLS
Musculoskeletal		Injection/aspiration - Large joint, bursa, ganglion cyst, trigger point - Small and medium joint injection Splint placement	
Pulmonary	Chest X-ray interpretation Handheld spirometry		
Urgent Care and Hospital	Foreign body removal - Ear, nose	Eye procedures - Fluorescein exam - Foreign body removal – eye Lumbar puncture	Endotracheal intubation Ventilator management Thoracentesis Paracentesis Arterial line Central venous catheter Slit lamp examination
Gastrointestinal & Colorectal	Nasogastric tube Enteral feeding tube Fecal disimpaction Digital rectal exam		
Genitourinary	Urine microscopy Bladder catheterization	Newborn circumcision	
Anesthesia		Local anesthesia/field block Digital block	

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j. Nutrition requirement – refer at least three (3) patients with nutrition concerns during 3-year residency. **(PC, MK, ICS, SBP)**. This requirement is to be coordinated with Ms. Nancy Kuppersmith, RD, MS, LD. Even though the nutritionist will track resident and patient progress in this requirement, documentation by the resident via New Innovations is encouraged as confirmation.

k. Mental/Behavioral Health Longitudinal Rotation. This rotation is coordinated with Ms. Anne Mason (cell phone: 432-6453). The following is a table of the requirements:

1. Prime MD Screens	**/30**
2. Prime MD Assessments	/21
3. Balint Group Sessions	/12
4. Behavioral health	
a) Patient identified?	
b) Discussed progress/co-treated with Mental Health Specialist?	y/n
5. Mental Health	
a) Patient identified?	
b) Discussed progress/co-treated with Mental Health Specialist?	y/n
6) Referrals	
a) Make referrals?	
b) Presented at core conference?	y/n
7) Work with family	
a) Patient/family identified?	
b) Discussed progress/co-treated with Mental Health Specialist?	y/n

3. Prior to sitting for the American Family Medicine Board examination residents are required to complete fifty (50) MC-FP points:
   a. Must include a minimum of one Part II Self-Assessment Module (SAM)
   b. One Performance in Practice Part IV module with data from a patient population (or an ABFM approved alternative Part IV activity with patient population data)
   c. The 50 MC-FP points can be obtained by completing additional MC-FP module(s) of choice
   d. Residents will continue to have free access to all of the ABFM's MC-FP assessment tools.
4. Residents are encouraged to take ABFM Boards in April of their third year of residency. The residency will pay for Boards in taken in April.
5. A resident has seven years after the completing of training in which to become certified. Furthermore, any physician who does not become certified within three calendar years after successful completion of residency training will be required to complete the MC-FP Entry Process in order to take the examination. This process includes:
   a. Completing of fifty (50) points including at least one Part II Self-Assessment Module (SAM) and one approved Part IV activity
   b. Completion of 150 credits of acceptable continuing medical education
   c. Three (3) MC-FP Process Payments
   d. Submission of application for the examination with full payment of the examination fee.

Those PGY3 who fail to meet the above criteria may have their residency extended in order to meet the requirements to sit for the certification examination of the American Board of Family Practice. **Please note - a resident may complete all requirements for the residency program and yet fail to gain the Department's recommendation to sit for the Board Certification Examination.** No resident shall be denied this recommendation without being placed on probation and given written notice that eligibility to sit for the certification examination is in jeopardy.

3.3 Academic Warning, Probation, Dismissal, and Appeals

3.3.1 Unsatisfactory Evaluation

If a resident receives an adverse evaluation from outside the Department of Family and Geriatric Medicine, the Program Director will discuss the evaluation with the preceptor of the outside rotation. This information will be presented to the Family Practice Residency Promotion Committee for a recommendation of action. The committee may take any one of the following actions:

1. The resident receives unconditional credit for the month;
2. The resident receives credit for the month pending the fulfillment of some additional requirements; or
3. The resident receives no credit for the month's rotation, training will be extended, and the rotation must be repeated.

The Residency Promotion Committee may recommend that the resident be placed on academic warning. The resident has the ability to appeal the decision by the process outlined in section 3.3.6 below.

3.3.2 Remediation

Family Medicine residents may use no more than one month of elective time for remediation during the standard 36 month residency. If additional remediation is required, then the length of the residency will be extended in all cases. Based on consideration by and recommendations from the Residency Promotion Committee, any remediation may require an extension of the residency. This is decided on a case-by-case basis.

3.3.3 Department Academic Warning

A resident whose performance is below standard may be placed on "academic warning". This time frame may be up to three months at the discretion of the Residency Promotion Committee. The resident will be given in writing a list of the perceived problems. This document will contain a list of actions to be taken by the Department to help correct these weaknesses or problems. It will also clearly define how the resident will be evaluated at the end of the warning period. The options available to the Department and resident at the end of the warning period will be given to the resident in writing. Failure to fulfill the requirements of the academic warning period may be grounds for the issuance of University probationary status. The resident has a right to appeal the issuance of warning status, by submitting a written request to the Program Director.

3.3.4 University Probationary Status

House Staff in University of Louisville School of Medicine residency programs are classified as students (see item #7 in the House Staff Agreement) and as such, are covered by the Student Academic Grievance Policy and Procedures outlined in The Redbook, Chapter 6, Articles 6.6 through 6.8.14. Articles 6.6.3 (http://louisville.edu/provost/redbook) grant each academic unit the responsibility and authority to make

decisions in accordance with standards determined by the unit. Academic units are also responsible for seeing that the standards determined are in agreement with their respective RRC and Board requirements. The procedure to be followed when academic probation is recommended by a unit is:

1. Program Director makes recommendation to the Department Chairman.
2. Department Chairman makes written recommendation to the Dean. The written recommendation should include the reasons for the recommendation, the length of the recommended probation (usually three months, at the discretion of the Residency Promotion Committee), and the expected resolutions to the problems.
3. The Dean reviews the recommendation and informs the resident of the probation action.
4. At the end of the probationary period, the Department Chairman informs the Dean in writing of the resident's progress, advising the Dean if the problem is resolved, if an additional period of probation is necessary, or if dismissal is recommended. The Dean takes the appropriate action.

At the time the probationary status is issued, faculty members will meet with the resident to discuss the resident's weaknesses. The resident will be given in writing a list of the perceived weaknesses. This document will also be placed in the resident's file. It will contain a list of actions to be taken by the Department to help correct these weaknesses or problems. It will also define how the resident will be evaluated at the end of probationary period. The options available to the Department and the resident at the end of the probationary period will be given to the resident in writing. Failure to fulfill the requirements of the university probationary status may be grounds for dismissal from the residency program. The resident has the right to appeal being placed on academic probation. The Student Academic Grievance Procedure provides residents a fair means of dealing with actions or decisions which the resident may feel to be unfair or unjust. The School of Medicine Student Academic Grievance Committee includes resident representatives.

3.3.5 Dismissal

Grounds for immediate dismissal of a resident from the residency program include the following:

1. Criminal activity (suspension may occur pending the outcome of due process),
2. Unethical behavior,
3. Impairment due to substance abuse (suspension may occur while the resident undergoes treatment), or
4. Contract violations.

Dismissal may also occur because of unsatisfactory performance at the end of a probationary periods outlined above. The resident has a right to appeal dismissal.

3.3.6 Appeals Process

If actions taken by the faculty are not satisfactory to the resident, then the resident may initiate an appeals process. The resident should start the appeals process by submitting in writing their wish to challenge the faculty action. The resident may then appear before the Residency Promotion Committee to appeal an adverse action. The Residency Promotion Committee may then reconsider the matter. If the resident remains dissatisfied with the action, then the resident may initiate an appeal in accordance with the University of Louisville Appeals Policy. Refer to: University Redbook (http://louisville.edu/provost/redbook) and/or the House Staff Policy Manual (http://louisville.edu/medschool/gme).

3.3.7 Procedure for Leaving the Program

Residents may leave the program by resignation, termination, non-renewal of contract, or upon graduation. If a resident feels it is necessary to leave before completing the three years of training, the resident should request a meeting with the Program Director to discuss their departure and the rationale for such. At that time, if the resident still feels it is necessary to leave, the resident should submit to the Program Director a written resignation at least 30 days prior to departure. Beyond the moral obligation of honoring a written contract, courtesy to the program and the resident's peers would dictate at least thirty days advance notice to accommodate for coverage of the resident's previously assigned duties.

When a resident leaves the program, he/she should return all departmental office keys, return beeper, and return educational materials that may have been borrowed from the program. The ABFM will be notified of the separation from the program. An exit interview will be mailed to the resident approximately three months after graduation from the program.

3.4 Leave Time

3.4.1 Definitions

For purposes of call and leave:

Day = 24 hour period (begins at 8:00 A.M. one day to 8:00 A.M. the next day)

Week = 8:00 A.M. Sunday to following Sunday at 8:00 A.M.

Month = 8:00 A.M. on 1st of month to 8:00 A.M. of the 1st of the next month as defined by the University "Universal Change of Service" schedule per year.

The American Board of Family Medicine allows 30 days maximum leave per year including: vacation, sick leave, personal business, leave. If the resident is away from the program for more than 30 days in any year then, not including educational time, the resident must discuss possible extension of the residency with the Residency Director; (https://www.theabfm.org/cert/absence.aspx).

Special Note Concerning Interviewing: Per ABFM regulations, which state that a resident cannot be away from the residency program for more than 30 days in one year without extending the length of residency, third year residents **cannot** be given extra time off for job interviews. Interviews should be scheduled during time the resident already has scheduled off during the year.

Residents are required to call the Residency Coordinator's (or Residency Office) during illness. The Program Office will notify the medical office and the rotation of the resident's illness. As a rule, each level is expected to cover illness occurring within their ranks; however it is hoped other house staff will demonstrate mutual concern for their colleagues by helping out, especially in exceptional cases (not excluding Chief Residents). The Chief Resident will attempt to arbitrate what is equitable to all concerned. If an illness is serious, prolonged, or requires hospitalization, the Chief Resident will arrange for other House Officers to substitute. Refer to House Staff Policy Manual (http://louisville.edu/medschool/gme) for further discussion of sick leave and disability benefits.

3.4.2 Vacations/Holidays

The American Board of Family Medicine guidelines state that vacation periods may not accumulate

from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time (https://www.theabfm.org/cert/absence.aspx)

All PGY1 residents shall be entitled to three weeks of vacation during a twelve month period.

All PGY2 and PGY3 residents shall be entitled to four weeks of vacation during a twelve month period.

Vacations do not accrue from one year to another. Vacations usually occur during a calendar week (e.g., 7 days - Sunday through Saturday inclusive); weekends are counted as days of leave. A resident must complete three weeks (21 days) of any month block rotation. Therefore, a resident may take two weeks of vacation leave concurrently only between rotations (e.g., last week of one month and first week of the next.) A resident may also take two weeks of vacation in conjunction with a half month block rotation. Vacations are to be arranged (during the March planning period) by the Chief Residents with help from the Program Coordinator for the up-coming academic year. Once established, vacations times are not changed except in special situations. In general no vacations are scheduled during the following times:

PGY1's: July; last Friday in October; December 20 - January 1; June 16 - June 30
PGY2's: July 1 - July 15; last Friday in October; December 20 - January 1; June 16 - June 30
PGY3's: July 1 - July 15; last Friday in October; December 20 - January 1; June 16 - June 30

In general, PGY3 residents who are "off-cycle" (completing training on a date other than June 30) should not schedule vacation during the last 15 days of their residency. Whenever possible, schedulers try to accommodate a week's vacation by not placing the resident 'on call' the night before a vacation starts and the night after a vacation ends. **Please be aware that this might be done as a courtesy only -** it is not a requirement and the rotation is under no obligation to change their schedule for you.

3.4.3 Educational Leave

The resident may request educational leave during the PGY2 and PGY3 provided the resident is in good standing with the program. A maximum of five days per year/7 days total for two years of leave time can be granted. The program will reimburse the resident up to $500.00 per year for expenses incurred for educational leave.

If the resident chooses not to spend the $500.00 during the PGY2 he/she will be allowed to spend $1000.00 in PGY3 for CME. If the resident chooses not to spend the money on CME he/she can spend up to $500.00 on approved educational material in PGY3; to be determined by the Program Director. Allotment for CME, up to $250.00 per year may be used for purchases related to the education of the resident; to be determined by the Program Director.

Educational leave consists of conferences that have been approved for prescribed CME credit by the American Academy of Family Physicians. In addition a resident may attend an ATLS, NALS, or PALS course.

Only PGY2 and PGY3 residents who are in good standing are eligible for educational leave. Good standing is defined as not being on academic warning or probation, and meeting the overall core conference and grand round attendance policies.

The resident must seek approval to attend conferences in writing at least six weeks in advance. This

should be submitted to the Program Director with a copy of the conference announcement. The resident must first pay for expenses incurred and submit original receipts and request reimbursement following the conference. Reimbursement will occur only for legitimate expenses incurred for lodging, conference registration, and travel.

3.4.3 USMLE Step 3

This exam must be successfully completed in order to fulfill PGY1 promotion criteria and move into PGY2. It cannot be scheduled during FMHS or ICU/Critical Care rotations. The resident should inform the rotation that he/she will be working of this possibility and receive their approval prior to schedules being established so that the time away for testing can be built into the rotation schedule.

3.4.4 Leaves of Absence

Leave of absences shall be granted for a one month block of time. Residents who need less than one month leave of absence are advised to use vacation or sick time, whichever is appropriate. Before a leave of absence is granted, the resident must request the leave of absence in writing that will be submitted for discussion at the monthly Resident Promotion Committee Meeting for approval. The American Board of Family Medicine must approve any leaves of absence of two months or more. More Board information is located at: https://www.theabfm.org/cert/absence.aspx

House Staff Policy **requires** the resident to take care of their medical records prior to leaving for vacation, out-of-town rotations and leaves of absence.

Residents who take a leave of absence for more than 15 days must designate someone to take care of any medical records problems that come up during the leave. Before the program can approve a leave of absence, a LOA form must be submitted to the Associate Dean for GME along with a Resident Promotion Committee approved request for leave. These forms are to be obtained from the Program Coordinator. LOA's will not be approved without the signed medical records transfer form. This will not apply in cases of sudden and unexpected personal illness, but will apply in all other cases including LOA's for maternity leave and personal reasons.

In cases of personal illness, the Program Director will designate someone to take care of any delinquent medical records for that resident.

NOTE: Because the ABFM and U of L policies differ, it is possible for the University to pay the resident for more months than the ABFP will give credit.

3.4.5 Off-Site Rotations

A resident may take no more than three rotations off-site. Two of these must be in rural Kentucky under the auspices of the AHEC (Area Health Education Center) program. A third off-site rotation is allowed and it may be taken in or out of the state of Kentucky or outside of the United States. This rotation will count as an elective rotation and categorized as a "Community Medicine" rotation. A resident may take no more than two off-site rotations in a given academic year.

If the resident chooses an elective which entails being away from the program for a month, the resident must submit a Rotation Proposal, based on and specifically citing the six ACGME core competencies. This proposal must include:

OFF-SITE ROATION PROPOSAL

Rotation dates:

Location :

Contact person (mail supervisor):

Address:

Educational goals (what you plan to learn during this rotation):

Duties (what exactly you are doing on this rotation):

Product of Evaluation to be done in the residency, to be defined before the onset of the rotation and approved by resident advisor or Program Director. Options include:

1. Lecture
2. Paper
3. Other

Revised July 2013

3.4.6 Request for Leave/Coverage

The resident will use the "Leave Coverage Form" following this section to arrange coverage for their patients any time the resident is on a leave (vacation, sick or CME).

3.4.7 Coverage for Rotations

If a resident is involved in a rotation where it would be difficult having to leave to cover their OB patients, *i.e., any upper level completing a first year rotation, an ICU month, etc.* the resident must get coverage for their OB patients. Normally, the resident should be available by phone to cover their office and nursing home patients. This requirement impacts patient care directly and reflects on professionalism and interpersonal skills and communication.

LEAVE REQUEST FORM
(Includes: Vacation, Educational Leave, Leave of Absence, Off Site Rotation, Other)

Name of Resident:

Dates:

Scheduled Rotation:

Purpose of Leave:

Coverage: (Print Name along with Signature)

Clinic Patients*:

OB Patients*:

Nursing Home Patients*:

* PGY2 and PGY3

APPROVAL:

Residency Program Director: Date:

____ _________________

<u>This form must be submitted at least six weeks in advance of leave for educational leave. A copy of the brochure of the educational program must accompany this request.</u>

cc: Covering Physician(s)
Program Staff

Reviewed July 2013

3.5 Benefits

3.5.1 Professional Coats

The Department will provide three monogrammed lab coats for each new PGY1 resident upon entering the program. It is the resident's responsibility to purchase new lab coats, as needed, for the remaining two years. It is also the resident's responsibility to maintain a professional appearance at all times. Coats should be clean and pressed on a regular basis.

3.5.2 Payment for Examinations

The Department will pay for the one-time cost of USMLE Step 3. The Department will also pay for the American Board of Family Physician certifying examination if taken in April of his/her PGY3. The resident will speak the Program Coordinator to arrange payment prior to taking the test. Payment will not be made after taking the test. Payment will be made only for those examinations taken while the individual is a resident at the University of Louisville. Residents who need to repeat any of these examinations will do so at their expense

3.5.3 Payment for AMA, AAFP, GLMS

The Department will pay for membership dues for the AMA, AAFP, and GLMS. All residents are encouraged to join these organizations.

3.5.4 Reimbursement for Educational Conferences, Educational Material, Examinations, Dues to Professional Organizations

If residents have presentations at conferences the Department will reimburse up to $2000.00. After that amount the Residents CME money will be used at the discretion of the Department. Although there may be instances that residents will present more than once a year it will be at the Department's discretion if more than one of these conferences is reimbursed. The resident must follow standard University reimbursement policies.

3.5.5 Beepers

The Program will provide beepers for all residents upon entering the residency program. PGY 2 and3 residents may **"opt out"** of using beepers and use cell phones for contact. It is the resident's responsibility to provide the Program with the preferred and correct contact number. The resident is to respond to a page or call as soon as possible when the Program is trying to get in touch with them. PGY1 residents must use beepers when on outside Department rotations. On call and back-up beepers are to be used by all residents when on the hospital service, night float, or back up.

3.6 Physician Impairment

Residents who exhibit signs of impairment due to substance abuse are referred to the Kentucky Physicians Health Foundation (KPHF) for evaluation in accordance with Kentucky medical licensure laws. KPHF evaluates and monitors impaired physicians for the Kentucky Board of Medical Licensure (KBML) under a formal contractual arrangement. The University follows the recommendations of this organization for the treatment and monitoring of impaired residents as well as the written policies of the University of Louisville Hospital. As residents begin training in University programs, they are required to complete a Hospital Privileges Application, which requires information about their personal health status and includes questions related to impairment due to alcohol and other drugs. These applications are

reviewed by the hospital Physicians Health Committee (PHC), which in turn makes recommendations to the hospital Credentials Committee. Residents who are in recovery are reviewed at quarterly meetings of the PHC. There is formal written exchange of information about the status of the resident's recovery between the PHC and the KPHF quarterly. Residents who are found to be impaired because of known and untreated substance abuse, or who violate the Kentucky licensure law are referred to the KBML as required by law.

Residents needing assistance or who have questions should contact their Program Director, the Medical Director of the Kentucky Physicians Health Foundation (Dr. Greg Jones at 425-7761), or the Chairman of the University of Louisville Hospital's Physicians Health committee (Dr. Christopher Stewart at 852-5387)852-5394.

3.7 Chief Residents

3.7.1 Chief Resident job description

Leader

1. Be an approachable and reliable resource for residents,
2. Be an advocate for residents in both intra- and inter-departmental settings,
3. Arrange and preside over monthly resident meetings
    a. These meetings will be held during regularly scheduled core conference hours.
4. Act as role models for exemplary behaviors including but not limited to
    a. Professionalism: giving and receiving feedback, work ethic, punctuality, and interactions with medical assistants and medical students,
    b. Enthusiasm: giving praise where it is due and advocating for the program
    c. Commitment: bettering the program and resident experience,
    d. Willingness: acting above and beyond the expectations for residents in areas of
    e. Patient care, including clinic, inpatient, as well as OB continuity deliveries,
    f. Integrity: being fair, just, and reliable,
5. Meet with each class of current residents towards the end of the academic year to discuss their new roles in the coming year and what will be expected of them,
6. Meet with the newly elected chiefs at the end of the year, before they are expected to step into their roles, to advise them on their roles,

Manager and Organizer

1. Design and troubleshoot the yearly rotation schedule, which will be completed and turned into the Program Coordinator as early as possible (early April).
2. Troubleshoot clinic and inpatient coverage issues.
3. Communicate upcoming events such as resident meetings, surveys, and extracurricular events,
4. Promote collegiality,
5. Coordinate activities that build a spirit of community and relationships,
6. Model teamwork and collegiality by working with co-chiefs to present a unified front,
7. Avoid complaining to or in front of other residents,
8. Ensure that feedback is constructive in nature.

Communicator, Negotiator, and Problem Solver

1. Act as an intermediary between the residents and program director/administration,
2. Manage conflicts between residents,
3. Hear all sides of a conflict and work to find equitable and just solutions,
4. Strive to be a part of problem solving when conflicts arise,

5. Involve residents in major changes by communicating and hearing feedback to be passed along to administration.

Counselor

6. Reach out to incoming interns regularly (at least monthly for the first 3 months) as well
7. as other residents to check in and offer support,
8. Be available and approachable to residents for personal and professional concerns.
9. Be alert to signs of depression, fatigue, stress, and substance abuse among residents.
10. Know of and suggest additional resources to residents as appropriate.
11. Maintain resident confidentiality unless patient or resident safety is in question, or if a situation is of particular concern and the program director should be notified.

Clinician

1. Be punctual for all shifts,
2. Demonstrate respect for patients and families,
3. Complete documentation, notes, and charts promptly,
4. Give clear and efficient sign-out,
5. Interact professionally and effectively with consultants, nurses, MAs, and team members,
6. Use the backup system appropriately.

Teacher

1. Foster a spirit of inquiry and scholarship within the department,
    a. Take senior scholarly project seriously,
    b. Support and encourage residents who engage in scholarly activities,
2. Seek out opportunities to teach residents and medical students,
3. Seek out and provide feedback regarding teaching skills,
4. Actively participate in teaching conferences,
    a. Presenting at least two lectures of your choosing in addition to other conference requirements,
    b. Being on time for and engaged in lectures given by others.

Developed by Chief Residents July 2013

3.7.2 Selection

Chief Residents will be recommended via a resident ballot composed of eligible residents, i.e., those with at least six months remaining in their PGY3 and in good standing in the program when they assume their duties. The Residency Promotion Committee will approve the residents' candidates of choice.

3.7.3 Term

Chief residents will generally serve for no less than six months and no more than 12 months. Chief residents receive $200 a month for reimbursement of their services.

3.8 Family Medicine Residency Program Policy on Resident Duty Hours

The educational goals of the Residency Training Program and the learning objectives of the residents must not be compromised by excessive clinical service obligations. The intention of this policy is to foster resident education and facilitate the care of patients. This policy covers all rotations/institutions to which Family Medicine Residents participate.

Resident duty hours and on-call time periods must not be excessive. It is recognized that clinical services vary over time in the number and complexity of patients. The Residency Training Program strives to structure duty hours and on-call frequency to assure the acute and continuity care needs of the patient, as well as the educational needs of the resident, are met. In all instances, duty hours and on-call frequency must comply with the ACGME Institutional and Program requirements in Family Medicine.

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer to patient care, time spent in-house during call activities, and scheduled academic activities such as conferences.

1. **PGY1 Residents**

    a. Maximum Hours of Work per Week:
        i. Resident work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

    b. Mandatory Time Free of Duty:
        i. To prevent excessive fatigue and sleep deprivation, residents must have at least one day out of seven, averaged over a four week period, free of duty.

    c. Maximum Duty Period Length:
        i. Resident duty periods must not exceed 16 hours in duration.

    d. Minimum Time Off between Scheduled Duty Periods:
        i. Residents should have 10 hours off, and must have eight hours free, between scheduled duty periods for rest and personal activities.

    e. Supervision of First Year Residents:
        i. Residents should be supervised by directly or indirectly with direct supervision immediately available **(Refer to Supervision Policy 3.9)**.
            1. **Direct Supervision** of a resident requires the supervising physician being present with the resident and patient.
            2. **Indirect Supervision with Direct Supervision immediately available** requires the supervising physician be physically within the hospital or other sites of patient care, and is immediately available to provide Direct Supervision.

2. **PGY2 and PGY3 Residents**

    a. Maximum Hours of Work per Week:
        i. Resident work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

    b. Mandatory Time Free of Duty:
        i. To prevent excessive fatigue and sleep deprivation, residents must have at least one day out of seven, averaged over a four week period, free of duty. At-home call cannot be assigned on these free days.

    c. Maximum Duty Period Length:
        i. Residents may be scheduled for up to 24 hours of continuous duty in the hospital.
        ii. After 16 hours of continuous duty, especially between the hours of 10:00 pm and 8:00 am strategic napping is encouraged.

iii. Additional clinical responsibilities must not be assigned to residents after 24 hours of continuous in-house duty.

d. Exceptions to the Maximum Duty Period Length:
    i. Residents may remain on duty up to an additional four hours to provide effective transitions of care that are essential for patient safety and resident education.
    ii. In unusual circumstances and on their own initiative residents may choose to remain beyond their scheduled duty period to provide care to a single patient to provide required continuity for a severely ill or unstable patient, academic importance, or humanistic attention to the needs of the patient or family.
    iii. In this situation, the resident must hand over the care of all other patients to the team responsible for their continuing care and document the reasons for remaining to care for the patient in question and submit the documentation to the program director. The documentation must be submitted in the comment section for the Duty Hour entry in New Innovations.

e. Minimum Time Off between Scheduled Duty Periods:
    i. Residents should have 10 hours off, and must have eight hours free, between scheduled duty periods.
    ii. Residents must have a minimum of14 hours free of duty after 24 hours of continuous in-house duty.

f. Exceptions to the Minimum Time Off between Scheduled Duty Periods:
    i. As part of their preparation to provide unsupervised patient care over irregular or extended duty periods, residents in their final years of training may have less than eight hours free of duty within the 80 hour maximum duty period, and one day off in seven when circumstances dictate they must stay on duty to provide care for their patients or return to the hospital.
    ii. This must be documented in the New Innovations Duty Hour entry comment section for review and monitoring by the Program Director for every instance of overage.

g. Maximum Frequency of In-House Night Float:
    i. Residents must not be scheduled for more than six consecutive nights of night float.

h. Maximum Frequency of In-House On-Call Frequency:
    i. Residents must not be scheduled for in-house call no more frequently than every third night averaged over a four week period.

i. At-Home Call:
    i. Residents scheduled for at-home call who are called in must count the hours spent in the hospital toward the 80 hour maximum weekly hour limit. It is not limited to the every third night limitation, but must have one day in seven free of duty.
    ii. Residents may return to the hospital while on at-home call to care for new or established patients. Each period of time spent in the hospital must be included in the 80 hour weekly maximum, and does not initiate a new “off-duty-period”.

j. Supervision of PGY2 and 3 residents:
    i. Residents should be supervised by directly or indirectly with direct supervision immediately available **(Refer to Supervision Policy 3.9)**.
        1. **Direct Supervision** of a resident requires the supervising physician being present with the resident and patient.
        2. **Indirect Supervision with Direct Supervision immediately available** requires the supervising physician be physically within the hospital or other sites of patient care, and is immediately available to provide Direct Supervision.
        3. **Indirect Supervision with direct supervision available** (the supervising faculty if not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic

and/or electronic modalities, and is available to provide Direct Supervision.

3. **Moonlighting:**

    a. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program. **(Refer to Program Policy on Moonlighting, Policy Manual section 3.12)**.

4. **Resident Supervision:**
    a. Residents will at all times have appropriate support and supervision. **(Refer to the Program Policy on Resident Supervision, Policy Manual section 3.9)**.

5. **Stress and Fatigue:**
    a. Residents' stress and fatigue will be monitored by the Program Director. **(Refer to the Program Policy to Monitor Stress and Fatigue, Policy Manual section 3.10)**.

Academic Probation for Failure to Log Duty Hours:

All residents who sign contracts through the GME Office are required to enter their duty hours in the New Innovations (NI) system weekly. Residents who are found in violation of this requirement will be recommended for academic probation. The process for this recommendation is as follows:

1. The GME Office will generate an" hours logged" report for each program the first week of each month that will show which residents have not logged hours for the previous month (i.e., a report of residents who have not logged hours for December will be run the first week of January).

2. These reports will be faxed to the appropriate Program Directors by the 10th of each month. Program Directors or Coordinators are responsible for notifying the residents of the impending probationary action.

3. Once the reports are distributed, residents will be given until the 15th to enter the missing hours. The GME Office will provide the appropriate Program Directors with an updated report at the monthly GMEC meeting.

4. If the resident has not entered the missing hours by the last day of the month, it will be recommended to the Dean that the resident be placed on academic probation. A copy of the recommendation will be forwarded to the resident/fellow and the Program Director.

5. Once placed on probation, the resident will be given an additional 7 days to complete the appropriate duty hour entries. If not entered by the end of 7 days, a recommendation for suspension from program activities and payroll will be forwarded to the Dean.

6. Please contact the GME Office or the GME website at (http://louisville.edu/medschool/gme).

Reviewed July 2013

3.9 Family Medicine Residency Program Policy on Resident Supervision

1. Residents must be appropriately supervised by teaching staff at all times and in such a manner that each individual resident is allowed to assume progressively increasing responsibilities according to her/his level of education, ability, and experience. **The resident will have access to a supervisory attending at all times.** The Residency Faculty of the program along with the Residency Promotion Committee is responsible for determining the level of responsibility accorded each resident. This policy is effective for ambulatory settings, long term care settings, and hospital settings.

2. **Family Medicine Center (FMC)**

   a. The Residency Program will assure that there is always an appropriate number of supervising faculty who, without other obligations, are immediately available on-site to precept in the Family Medicine Center whenever one or more residents are seeing patients. Supervising faculty are permitted to precept a maximum of four residents at a time. In addition to their availability when needed by the residents, these supervisors must provide active precepting of the residents.

      i. PGY1

         1. During the orientation month the resident will perform five supervision checkout tools *. This is done with **Direct Supervision**. The supervising physicians will complete the forms and if the resident has successfully completed the five activities he/she will be allowed to have **Indirect Supervision with Direct Supervision immediately available** (the supervising physician is physically within the FMC, and is immediately available to provide **Direct Supervision**) throughout the rest of PGY1. However, all patients seen by PGY1 residents during the first six months must be checked out to and seen by the supervising attending.

         2. For the second six months of PGY1 every patient is to be reviewed by the preceptor prior to the patient leaving the clinic. The preceptor and the resident can decide if the patient needs to be seen.

         3. During the first six months of the PGY1 year, the resident will be evaluated every month by the Medical Director of the FMC with direct input from the precepting faculty. The evaluation is based on the ACGME six core competencies. At the end of the first six months the Residency Director along with the Residency Promotion Committee will use these evaluations to decide if a resident is capable of progressing to the next supervised level.

         4. If the resident is deemed to meet the requirements to progress to the next supervised level he/she will be allowed to function in the FMC with **Indirect Supervision with Direct Supervision immediately available**. However, patients do not have to be seen by the attending after checkout if deemed stable by the attending and the resident does not need assistance. If unable to meet the requirements to progress to this next level of supervision, the resident's patients will need to be seen at the

time of the visit by the attending until such a time that he/she is able to fulfill the requirements to this next level of training.

5. The faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

ii. PGY2 and PGY3

1. Residents in either PGY2 or PGY3 will have oversight of their clinic duties by **Indirect Supervision with Direct Faculty Supervision immediately available**.

2. PGY2 residents are to be precepted after every two patients. Patients may be discussed with the preceptor more frequently if needed.

3. PGY3 residents are to be precepted after every three patients. Patients may be discussed with the preceptor more frequently if needed.

3. **Family Medicine Hospital Service (FMHS)**

a. The Residency Program reviews the monthly call schedule that clearly identifies the primary on-call resident, the resident on night float, the resident on back-up, and the supervising resident as well as the supervisory attending physician. The schedule contains pertinent information (telephone number, beeper number, etc.) necessary to quickly and efficiently contact those in the chain of command. Copies of the call schedule are available to the residents and key personnel at the training sites (FMCs, hospital operators, etc.). It is the responsibility of the Residency Program to keep the call schedule current and accurate. In the case of an emergency in which someone is unable to fill his/her call responsibilities, volunteers from the available resident group will be solicited or assigned by the Chief Resident. If volunteers cannot be solicited, the Residency Program will assign residents to assume call responsibilities. This might necessitate changing rotational obligations for the effected time period.

i. PGY1

1. During the PGY1 residents are required to rotate on the FMHS two times (two months). During the orientation month the resident will perform five supervision checkout tools*. This is done with **Direct Supervision**. The supervising physicians will complete the forms and if the resident has successfully completed the five forms he/she will be allowed to have **Indirect Supervision with Direct Supervision immediately available** throughout the two PGY1 FMHS months. This supervision of the PGY1 resident may be carried out by the Faculty Attending or PGY2 or 3 residents once delegated to this supervisory role by the Program Director and the Residency Promotion Committee.

ii. PGY2 and PGY3

1. Residents in either PGY2 or PGY3 who have may function in a supervisory role if delegated to by the Program Director and the

Residency Promotion Committee using evaluative material based on the ACGME six core competencies. These residents must have **Indirect Supervision with Direct Supervision available** (the supervising faculty if not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide **Direct Supervision**).

b. **Residents must have access to a supervisory faculty at all times** to ensure appropriate communication occurs in all areas of patient care. The supervisory faculty must be notified immediately and available to assist with:

   i. Transfer of a patient to an intensive care.
   ii. Required continuity of care for a severely ill or unstable patient.
   iii. Humanistic attention to the needs of a patient of family such as end-of-life decisions.
   iv. Events of exceptional educational value.

4. **OB Longitudinal Care and Nursing Home Care**

   a. Both of these areas of resident education occur during PGY2 and PGY3. Residents who have graduated to either of these two years of training must have the following levels of supervision:

      i. OB Longitudinal Care

         1. Residents in PGY2 or PGY3 must have **Indirect Supervision with Direct Supervision immediately available**.

      ii. Nursing Home Care

         1. Residents in PGY2 or PGY3 must have **Indirect Supervision with Direct Supervision immediately available**.

5. If residents are at any time concerned about the availability or level of supervision, they should contact the Program Director, the Departmental Chairman, the Assistant Dean for Educational and Work Environment, the Resident Ombudsman to the Subcommittee on Resident Educational and Work Environment, or the office of Graduate Medical Education of the University of Louisville School of Medicine.

6. Compliance with the RRC's requirements for resident supervision must be attested to in the periodic internal review.

Reviewed July 2013

***Supervision Assessment Tool (to allow indirect supervision)**

________________________________ ________________________________

Person Being Assessed /PGY 1 Person Doing the Assessing /PGY level

____

Date

Medical Knowledge		
Able to provide a differential diagnosis	YES	NO
Addresses the pathophysiology of the working diagnosis	YES	NO
Understands significance of lab / imaging results	YES	NO
Clinical Skills		
Obtains an appropriate history	YES	NO
Physical findings are correctly assessed	YES	NO
Able to identify the most likely diagnosis	YES	NO
Provides a plan appropriate for the working diagnosis	YES	NO
Professionalism		
Follows up on lab results	YES	NO
Models professional behavior	YES	NO
Understands protocols and expectations	YES	NO
Practice Based Learning and Improvement		
Identifies reading source	YES	NO
Identifies patterns in patient populations	YES	NO
Communication and Interpersonal Skills		
Presentation is concise and accurate	YES	NO
Charting is reflective of the encounter	YES	NO
Systems Based Practice		
Works well with other members of the team	YES	NO
Requested appropriate consultation	YES	NO
Understands how to obtain appropriate Consultation or testing	YES	NO
Considers insurance restrictions (if applicable)	YES	NO

Reviewed July 2013

3.10 Policy on Monitoring Physician Impairment, Stress, Fatigue, and Sleep

The Residency Training Program of the Department of Family and Geriatric Medicine understands that this is a very important area of resident education. In order to monitor stress and fatigue in residents, we have developed the following policy to insure that the best possible recognition and guidance can be given in these areas. In addition residents and faculty are educated in recognizing these issues.

1. Each resident will be paired with Residency Program Faculty (Senior Faculty for Resident Education, Assistant Residency Director, or two Residency Faculty) as her/his advisor. Each advisor is assigned six residents. The advisor and resident meet at least quarterly. During these sessions the advisor specifically discusses physician impairment, stress, fatigues, and sleep deprivation with the resident. Specific topics covered include: relations with family and friends, adjustment to community (self, family), time for self, work hour requirements, and special stressors that the resident might have at that time. The advisor will help the resident with any problem area. If more help is needed, the advisor, with the permission of the resident, will discuss needs with the Program Director, Residency Faculty, and/or the Residency Promotion Committee.

2. The faculty and staff at the individual FMCs will aid in the monitoring of physician impairment, stress, fatigues, and sleep deprivation. Residents in Family Medicine spend a great deal of time in their continuity clinics. The faculty preceptors have a considerable amount of time with the residents and will discuss stressors and fatigue with them. The staff members at the individual clinics also play a role in this area. Many have worked at the sites for several years and have the ability to recognize physician impairment, stress, fatigues, and sleep deprivation. When issues arise, staff will discuss them with either the preceptor for the day or the Medical Director. Any concern that cannot be addressed at this level will be discussed with the Program Director.

3. While on the Family Medicine Hospital Service the attending will monitor the residents for stress and fatigue issues. As above, any issue that cannot be properly addressed by the attending will be discussed with the Program Director.

4. The Program Coordinator and residency office staff play a role in monitoring stress and fatigue. The Program Coordinator spends a great deal of time one-on-one with the residents and strives to address any concerns that the residents might have. The office staff's experience working with the residents aids in the recognition of problems. Possible issues noted will be discussed with the Program Coordinator or the Program Director.

5. The Chief Residents also will monitor for stress and fatigue in their fellow residents. The Chief Residents participate in the Residency Promotion Committee and will offer valuable information to the Program Director concerning this area.

6. The Program's mental health specialist (Marriage and Family Therapist) meets with the residents on a regular basis (up to six times a year). She discusses specific issues that the residents might have concerning impairment, stress, fatigues, and sleep deprivation. She is a resource for the Program Director as a counselor to the residents. The Program Director will also use the counseling and mental health professionals available within the University and School of Medicine to assist with needs that might arise.

7. The program will conduct a curriculum that will be presented to the residents and faculty yearly that discusses and trains these individuals in physician impairment, stress, fatigues, and sleep deprivation with the residents and faculty. *Reviewed July 2013*

3.11 Family Medicine Residency Transition of Care Policy

Transition of care (sign-out) for the Family Medicine Hospital Service occurs three times a day; mornings, mid-day, and evening. The sign-out will include written as well as verbal communication. The sign-out will utilize the daily written list of patients. The verbal portion of the sign-out will utilize all points of the SIGNOUT template at every sign-out. The process of sign-out will be monitored by the attending on service. The following are the required times and individuals involved in transition of care.

S – Sick or DNR (highlight sick or unstable patients, identify DNR/DNI patients)
I – Identifying data (name, age, gender, diagnosis)
G – General hospital course
N – New events of the day
O – Overall health status/clinical condition
U – Upcoming possibilities with plan, rationale
T – Tasks to complete, rationale
? – Any questions (sign-out to be an interactive process and questions are to be asked)

6:30 a.m. to 7:30 a.m.

Monday through Friday morning the night float resident will meet with the senior resident on the hospital team to conduct sign-out face-to-face. This will occur during the specified times.

The night float resident will communicate directly with the attending on service either face-to-face or by telephone. This will occur during the specified times.

The upper level resident on the hospital team who is on call Friday and Saturday night will meet face-to-face with the hospital team at 8:30 a.m. to conduce sign-out.

For all sign-outs, all new admissions as well as any overnight events will be discussed.

Mid-day prior to residents who are required to attend clinic leave

The entire hospital team will meet face-to-face to discuss all new admissions, morning events, and all work that needs to be completed for the afternoon.

This process will occur on Saturdays and Sundays in a similar fashion prior to the residents who are relieved of duty leave for the day.

6:00 p.m.

Sunday through Thursday evening the night float resident* and the senior resident on the hospital team will meet to conduct face-to-face sign-out. All elements of the SIGNOUT template will be used.

Friday and Saturday evenings an upper level resident from the hospital team is on call and will meet face-to-face with other team members to conduct sign-out. All elements of the SIGNOUT template will be used.

**No PGY-1 resident will be on call overnight.

Reviewed July 2013

3.12 Family Medicine Policy on Common Circumstances Requiring Attending Faculty Involvement

ICU or complex patients

The attending faculty will participate in the daily care of ICU or complex patients by rounding and seeing every patient on a daily basis.

The night float resident or upper level resident (PGY-2 or 3)* on call will call the attending faculty member at night with all ICU admissions/transfers. The faculty and resident will discuss the patient and the decision for the faculty to return to the hospital will be determined at that time. The faculty must see and write a note on all ICU patients within eight hours of admission.

The night float residents or upper level residents (PGY-2 or 3)* on call will contact the attending faculty for all complex patients if he/she requires help in the decision making processes. The faculty and resident will discuss the patient and the decision for the faculty to return to the hospital will be determined at that time.

DNR

The attending faculty is to be involved in every aspect of patient DNR status. The decision to institute DNR orders will always be approved by the attending faculty. The night float resident or upper level resident (PGY-2 or 3)* on call writes a DNR order the attending faculty is to be notified and the decision discussed. All DNR orders written by a resident are to be signed by the attending faculty within 24 hours.

End-of-Life Decisions

The attending faculty is to be involved in all decisions pertaining to end-of-life. The attending faculty will model appropriate end-of-life decision making processes. At no time is a resident to make end-of-life decisions without the active involvement of the attending faculty.

The attending faculty will return to the hospital at night if a patient is actively dying unless the process is expected and discussed during the day. The attending faculty is to be notified if a patient is dying.

*No PGY-1 resident will be on call overnight.

Reviewed July 2013

3.13 Family Medicine Residency Program Policy on Moonlighting

1. While not required, residents shall be free to use off-duty hours in appropriate related activities, including engaging in outside employment activities (moonlighting). Such activities are subject to all stipulations of the "Resident Moonlighting Policy" of the University of Louisville School of Medicine.

2. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

3. Moonlighting is not permitted during PGY 1 rotations, even if PGY 1 rotations are completed during PGY 2 or 3 years.

4. There will be no moonlighting during the Family Practice Hospital Service, Geriatric Hospital Service, or the ICU/critical care rotation.

5. Moonlighting will be permitted only for hours that the resident has no rotational or residency obligations.

6. Time spent by residents in Moonlighting activities must be counted towards the 80-hour Maximum Weekly Hour Limit. All Moonlighting hours are to be logged into New Innovations on a weekly basis.

7. Moonlighting privileges are not permitted during periods of academic warning or probation.

8. Residents are not to represent themselves to moonlighting employers as being fully trained in their specialty. Further, residents who moonlight are not to represent themselves as agents of the University of Louisville during moonlighting activities.

9. The Residency reserves the right to deny or revoke moonlighting privileges if the Department Chair, Program Director, or Residency Faulty has reason to believe that the resident is having difficulties functioning in the residency. Furthermore these privileges may be revoked if any of the above stipulations are not met.

10. Residents found to be in violation of any of the above points, will result in loss of moonlighting privileges for the remainder of their residency. Furthermore, residents found to be in violation of any of the above points will be subject to progressive disciplinary action as detailed in the University of Louisville School of Medicine House Staff Agreement. This disciplinary action consists of academic warning, University probation followed by eventual termination in accordance with the policies outlined in The Redbook.

By signing this document I agree to comply with all of the above points and understand the repercussions of failing to comply with all of same points. If I choose not to engage in moonlighting at this time I will notify the Residency Program with any changes in this decision immediately as well as agree to comply with all of the above points.

___________________________	________	___________________________	________
Resident	Date	Program Director	Date

I **will be** engaging in moonlighting activities during the upcoming academic year.

___________________________	________
Resident	Date

I **will not be** engaging in moonlighting activities during the upcoming academic year.

Reviewed July 2013

3.14 GME Policy on Probation, Suspension, and Termination for Delinquent Medical Records at Affiliated Hospitals

1. A resident who is identified as having incomplete medical records (any record greater than 7 days past hospital discharge) by any of the Record Departments of the affiliated hospitals will be notified by the respective Medical Records department and given 7 days to complete the records in question. At that time, the resident will also be notified that if he/she does not complete the medical records within 7 days that he/she will be recommended to be placed on probation.

2. If at the end of the 7-day period the records have not been completed, the Director of Medical Records will notify the Associate Dean for Graduate Medical Education, who will recommend to the Dean that the resident be placed on probation. The resident will be notified in writing by the Dean of the probationary status.

3. Once placed on probation, the resident will be given 7 additional days to complete all additional records at all affiliated hospitals and notified that if records are not completed at the end of 7 days, the resident will then be recommended to be suspended.

4. The Medical Records Department of the appropriate hospitals will notify the Associate Dean for Graduate Medical Education if the medical records in question have not been completed at the end of the 7 days probationary period. The Associate Dean in turn will recommend to the Dean that the individual be suspended. The Dean will notify the individual resident of the suspension in writing. The Dean will notify the residents Program Director and the Chairman of the Department.

5. Suspension will include the following conditions:
    a. The resident will be relieved of all clinical duties.
    b. The resident will receive no credit for training while in suspended status.
    c. The suspension will continue until all delinquent medical records are completed.

6. If at the end of 30 days suspension period the resident has failed to comply, a recommendation will be made to the Dean from the Associate Dean that the resident be terminated/dismissed from the training program.

7. All available medical records should be completed prior to a resident departing for a vacation, leave of absence, or any out-of-town or out-of-state rotation since the above probation, suspension, and dismissal process will apply in these cases.

8. Prior to a resident departing from a program and receiving any credit or certification for the period of training, all medical records must be completed at all affiliated hospitals.

Reviewed July 2013

4.0 CURRICULUM INFORMATION

4.1 Family Medicine Office Responsibilities

It is the resident's responsibility to come to the office when scheduled, on time and dressed appropriately.

Professional Attire in Clinic:

It is the resident's responsibility to maintain a professional appearance at all times. Scrubs are not considered professional clinic attire. If there are occasions when scrubs are worn to clinic, they must to be covered with a clean white lab coat. There will be no exceptions to this requirement. Wearing scrubs daily is unacceptable.

A half day is:

8:15 a.m. to 12 noon
12:45 p.m. to 5:00 p.m.

Each resident is expected to comply with the policies and procedures of each FMC.

4.1.1 Changes in Office Schedules

Any changes in office hours need to be forwarded to the Program Coordinator for implementation. All rationales for alterations in office hours are subject to denial and appropriate office personnel will be notified of any approved or disapproved changes in schedules. FMC responsibilities are a major portion of the resident's core curriculum and are not to be treated lightly.

Office schedules can only be cancelled by the Program Coordinator or Program Director.

All residents, regardless of FMC, should assume responsibility for the care of their own patients. Clinical office personnel will notify the resident when there is a question or concern involving a resident's patient and the resident will arrange for the patient's care, whether it involves a phone call, an unscheduled office visit, or arrangements for another resident to see the patient. In the same manner, if office hours need to be canceled, the resident should review their schedule of patients and notify office personnel as to what arrangements need to be made for specific patients.

Morning and afternoon clinics may be cancelled if a resident is on the labor deck during clinic. *NOTE: If the OB-1 intern is available (i.e. not in OB or FM clinic or off) they will assist with any FM patients on the labor deck between 8am and 5pm and coordinate care/communication with the primary provider or covering FM resident as necessary. If the intern is not available, the triage nurse will page the primary provider or covering FM resident directly.*

4.2 Hospital Responsibilities

4.2.1 F MHS Composition

Typically, the service will consist of three to four residents: an upper level resident who works as service chief (usually but not always a PGY3) and two to three team members. If two or more upper level residents of equal experience are on the service, they will divide their time between service chief and

team member as evenly as possible, performing each role completely while assigned to it.

The service chief is responsible for assuring that, under the direction of the faculty attending, all patients are triaged, admitted, diagnosed, treated, discharged, and followed-up appropriately. She/he directs the team members and divides responsibilities and work as evenly as possible between them. This division includes, but is not limited to, patient numbers, patient complexity, and other team responsibilities, such as time spent carrying and responding to the primary call beeper.

The team members, regardless of PGY, are responsible for assuring that, under the direction of the faculty attending and service chief, their assigned patients are triaged, admitted, diagnosed, treated, discharged, and followed-up appropriately. Within the limits imposed by the office (continuity) requirements of their PGY, and other mitigating circumstances as specifically agreed to by the faculty attending and service chief, team members must divide service responsibilities and work as evenly as possible. This includes but is not limited to:

1. Dictate an H&P and discharge summary on all patients you admit and/or are assigned
2. Write admission orders as completely as possible. Orders will be reviewed as necessary by the back-up resident. Always include the primary call pager number in the admission orders. Voice any questions/concerns you have about the patient or the process – that is how you learn and the process is improved.
3. Daily notes should be written on all patients before rounds. The SOAP format should be used. These notes should include VS, I/O, current medications (and number of days of antibiotics and other key medications), current invasive treatments including number of days (central lines, endotracheal tubes, catheters, etc.), and a comprehensive assessment and plan that addresses all active medical problems. For ICU and other more complicated patients, a systems approach to daily note writing may work best. If possible, you should review the MAR and seek the nurse's input daily.
4. Be prepared to present your patients to the attending each morning at the assigned time.
5. Answer all pages promptly. If a confusing 4 digit page is received, try the phone prefixes for each hospital: ULH – 562; NH/KCH – 629; JH – 587.
6. At the end of rotation, off-service notes must be completed for each patient (unless they were just admitted). These are intended to make the oncoming team member knowledgeable concerning the patient's current problem list and medications, hospital course to date, tests/procedures performed and results of same, pending tests, and goals/plans for discharge.
7. Most importantly, remember that the Family Practice Hospital Service team is a team. The best teamwork comes when you put the "team" before the "work." Pull together and have fun. You will be amazed at all you will have learned by the end of the rotation!

4.2.2 Open Admission Policy

4.2.2.1 Internal Medicine/Family Medicine University of Louisville Emergency Department

1. Family medicine will admit the first two unattached patients requiring admission beginning at 7a.m. Monday-Friday and ending at 3p.m.
2. Patients who have established their care in the family medicine facilities at Central Station or Newburg Clinic for family medicine or the AIM clinic for internal medicine will be admitted to their respective services regardless of time of admission.
    a. Patients who have not been seen in the AIM clinic for more than 3 years are no longer considered established patients and would therefore be admitted as an unattached patient
    b. Patients who have not been seen in a family medicine facility for more than 3 years are no longer considered established patients and would therefore be admitted as an unattached patient
3. Patients who have been admitted to either the family medicine service or internal medicine service previously and require readmission in a calendar month in which they are discharged will be considered bounce back patients and will be admitted to that respective service regardless of timing of admission. Patients who are readmitted in another calendar month will be considered unattached patients if they have not established care in the family medicine or AIM clinics after discharge.
4. Patients who have been admitted to either the family medicine service or internal medicine service and require transfer to an ICU/CCU will be transferred back to that respective service.
5. The subset of patients who have not established care in a dialysis unit and require admission only for chronic dialysis will be considered unattached patients and be admitted to either family medicine or internal medicine as appropriate for the time and day. They are not considered bounce back patients even if they are readmitted within a calendar month.
6. Patients who receive subspecialty care only in the AIM clinic and do not receive primary care there are considered unattached patients and are admitted to the either family medicine or internal medicine as above.

4.2.2.2 Jewish Emergency Department

1. Family Medicine will admit up to two open call patients from 7:00 a.m. until 3:00 p.m. per week day, Monday to Friday.
2. If two open call patients do not come in during that time we will continue to take only one open call patient per day:
    a. If only one open call patient comes in during the above time that will be our one open call patient for the day.
    b. If no open call patient comes in during the above time we will still be responsible for one open call patient the rest to the day until 8:00 a.m. the next morning.
3. We will continue to take one open call patient on Saturday and Sunday.
4. Our service has a cap of 20 patients that we can have at any one time. It is the responsibility of the team to let the ED know when we are capped and when we are able to take patients again. This cap applies only to open call patients, we still take our own patients.

Revised July 2013

4.3 Night Float and On Call Responsibility

4.3.1 Security/Safety at Night

The Program stresses the importance of safety/security and strives to make all venues where the residents work as safe as possible. Appropriate safeguards are in place.

Our resident call room suite is located at Jewish Hospital, in the Residency Division Suite. It has a combination locked door as well as locks on the individual call rooms.

Our Program admits patients to four hospitals on the Health Science Campus; University of Louisville Hospital, Jewish Hospital, Norton Hospital, and Kosair Children Hospital. Of these four hospitals three are connected by covered pedways; Jewish Hospital, Norton Hospital, and Kosair Hospital. These pedways are covered, lit, and have continuous video monitoring. These pedways are always accessible.

The University Hospital is located three blocks from our resident call rooms at Jewish Hospital. This is an unsafe venue to travel after dark. Residents are discouraged from walking to the University Hospital at night. Residents wishing to walk to and from University Hospital and Jewish Hospital may call University of Louisville security at 852-6111. This escort service will either walk or drive them to the needed destination.

Residents routinely park in the Jewish Hospital parking lot free of charge. This parking lot is fully lit. There is a security guard on site 24 hours a day monitoring the parking lot. The lot can be accessed at all hours of the day without walking outside. In addition, at night residents have the ability to call security at Jewish Hospital 587-4484 to walk them to their cars in the parking lot.

Residents driving to the University Hospital at night may park in lit parking spaces next to the Emergency Department free of charge. There are security guards on site 24 hours a day.

Residents may park at the University Hospital (next to the Ambulatory Care Building) in this lot during the hours of 4:30 p.m. to 8:30 a.m. and all week-ends free of charge. This garage is fully lit and is connected to the hospital by a pedway. Residents may call University Hospital security at 562-3518 to escort them to the hospital from the parking garage. A second parking lot is located one block from the University Hospital (Chestnut Street garage). Residents who are on a service at the University Hospital overnight (typically OB nights or general surgery) have access to one of two parking permits to this lot. This permit may be obtained from the Program Coordinator prior to the above rotations. It is to be returned at the end of the rotation. The lot is fully lit. The residents have the ability to call the above number to escort them to the hospital from the parking garage.

Security/safety, especially at night are to be taken seriously and the above protocol should be followed.

4.3.2 GME Cab Voucher Program

The cab voucher program is designed to provide a safe way for residents to travel to and from campus or the Veterans Administration Medical Center post-call. All University of Louisville medical residents are eligible. Any resident who feels that he or she cannot drive home safely due to fatigue or excessive sleepiness should ask for a cab voucher. Cab Vouchers may be obtained at two locations:

1. HSC Campus Police Substation, Abell Administration Building, 1st Floor, 852-6111. (24 hours)
2. VA Campus, Admissions and Evaluation Unite, Room B-165, 287-6782.

3. You must have a form of ID for verification in order to receive a voucher. Instructions are included with the vouchers.

Once you have obtained the voucher, call yellow cab for pickup, 636-5511. Give the yellow cab service one of your vouchers, please retain the PINK copies of the vouchers, place them in the provided addressed, postage-paid envelope and mail back to the house staff council.

Confidentiality: Program directors, coordinators and fellow residents do not have access to any information regarding use of the cab voucher program. Only house staff council and the GME billing department may access this information.

4.3.3 Night Float

The FMHS uses a night float system that allows all duty hour requirements to be met and decreases the amount of stress and fatigue that can be encountered on call during residency.

Primary night float is completed in five-night blocks by second and third year residents daily, Sunday through Friday morning. Night floats starts at 6:00 p.m. and ends at 7:30 a.m. each day; call ends at 7:00 a.m. and residents have until 7:30 a.m. to check out with the day team, geriatric team, and attending. This week is effectively an "away" week, and the night float resident does not have clinic responsibilities during their week of night float. The chief residents are responsible for arranging coverage for the night float resident for continuity clinic, OB patients, and nursing home patients.

Residents eligible for a week of night float are residents doing elective months, medicine sub-specialties without vacation, gynecology without vacation, and cardiology without vacation. The only months during which night float will absolutely not be scheduled are FMHS, away rotations, geriatrics, and two-week RRC-required rotations.

Night float responsibilities include cross coverage phone calls, managing hospital patients over night, and OB triage when not doing hospital admissions. Family medicine interns on OB nights cover family medicine OB triage and labor deck duties. Residents can be called by the family medicine intern on OB for questions and deliveries on their continuity patients.

Admissions during the holidays are done by the hospital team until 6 pm and the night float resident overnight, Sunday evening through Friday morning as stated above.

The PGY2 or PGY3 on the FMHS will take call on Friday and Saturday night. In this way PGY1 residents will not be in house over night during this service.

During each academic year, second year residents do approximately four weeks of night float through the year, and third year residents do approximately three weeks of night float throughout the year.

Residents eligible for a week of night float are residents doing elective months, medicine sub-specialties without vacation, psychiatry without vacation, gynecology without vacation, cardiology without vacation. The only months with absolutely no pulling to the night float will be FMHS, geriatrics and 2 week RRC required rotations. Other months not mentioned are available on an as needed basis.

PGY1 residents rotate on several services: OB, Pediatric Wards, Private Surgery at Jewish Hospital, Newborn Nursery, Adult EM, and Pediatric EM. The call system is defined by the specific service based on new duty hour requirements. In OB there is a day team and a night float team. There is no call on the

day team. The night float team is Sunday through Thursday. There is no other call. Our residents rotate on both of these services. On Pediatric Wards our PGY1s work days only.

There is no call during the Newborn Nursery or Private General Surgery at Jewish Hospital. Adult and Pediatric EM have a shift work system in place that our PGY1s participate.

4.3.4 SECONDARY CALL ("BACK-UP CALL")

The chief residents will assign residents with either a "Limited" or "Full" Kentucky licensure to take "Back-up" call for potential help for FMHS on week-end.

4.3.5 PRIMARY OB CALL

All residents will be available for their assigned continuity OB patient deliveries.

4.3.5.1 Coordination with Family Medicine OB Rotator

The Family Medicine Resident on OB days will work as an integral part of the day team, concentrating on L & D and associated tasks. They will be able to primarily cover any FM patients presenting to Triage, and will coordinate such care with both the assigned FM continuity resident and the OB team/attending. The FM continuity resident will be contacted as labor progresses and is expected to participate in the key portions of labor and delivery. The goal for the OB-1 month is at least 15 deliveries. Our resident will be scheduled in OB clinic at least one afternoon per week for pre-natal exposure. The resident will also attend TAPP clinic one morning a week while on the OB day rotation.

The FM resident on OB nights will be on the night team. They will follow any FM patients in labor; otherwise they will be a regular member of the night team. The goal for the OB night month is at least 15 deliveries.

4.3.5.1 OB Policy

1. OB Patient Assignments
    a. PGY resident assignments
        i. After successful completion of 2 months of OB L&D rotations, first year residents may be assigned OB continuity patients from their continuity office or from the TAPP clinic. If the resident had exemplary evaluations following one rotation and is in the second half of his/her first year, they may be considered for assignment of continuity patients as well.
        ii. PGY1 residents should only be assigned OB patients whose expected date of delivery is after July 1 of their second year.
        iii. PGY1 residents should co-assign a second or third year resident to their continuity OB patients. It is easy to use an upper level resident who is also seeing patients in clinic that day. If there are no upper level residents in clinic that day, the first year resident should seek out an upper level resident during the next clinic day or when the initial prenatal lab results return. DO NOT CO-ASSIGN AN UPPER LEVEL TO YOUR PATIENT WITHOUT TELLING HIM/HER THAT YOU ARE DOING SO AND ALLOWING TIME TO REVIEW THE PATIENT'S CHART TOGETHER. Upper level residents are co-assigned because occasionally a patient will be admitted or seen in triage early in their pregnancy. The first year resident may be on a rotation that does not permit them to leave to see the patient on the OB floor, so the responsibility

shifts to the upper level resident to care for that patient. If the first year resident is on a rotation that permits leaving to take care of his/her OB patient, THEY SHOULD DO SO. The "co-assignment" period lasts until July 1 when the first year resident becomes a second year, at which point the upper level resident should be unassigned, with sole responsibility now on the former first year.

b. Assignment guidelines
    i. Patient assignments will be made based on the number of continuity patient deliveries and total deliveries that the resident has reported via New Innovations. Monthly tallies of delivery numbers are compiled and sent to attendings. This is the information we use to assign residents continuity OB patients.
    ii. IF YOU DO NOT LOG YOUR DELIVERIES IN NEW INNOVATIONS, YOUR NUMBERS ON THE TALLY LIST WILL REMAIN LOW AND YOU MAY CONTINUE TO BE ASSIGNED ADDITIONAL OB PATIENTS AHEAD OF YOUR COLLEAGUES, EVEN IF YOU HAVE DONE MORE DELIVERIES OR ARE CARRYING MORE THAN THEM.

2. TAPP Clinic
    a. TAPP directions
        i. South Park TAPP—From downtown take I-65 South to I-265; go west on 265 t the first exit (Fairdale exit). At the bottom of the ramp turn left and go under 265. The TAPP school is on the right immediately after going under the expressway. Phone number is 485-8946.
        ii. Westport TAPP—From downtown take I-71 north to I-265 (Gene Snyder). Go right (west) on I-265. The second exit is Westport Road. Go right on Westport Road about two to three miles. The TAPP school is on the left (8800 Westport Road). Phone number is 485-8125
    b. TAPP clinic times
        i. Tuesday morning is at South Park
        ii. Wednesday morning is Westport
        iii. Thursday morning is South Park
        iv. ALL clinics begin at 8:00 am and last until approximately 12:00 pm

3. OB List
    a. Passwords
        i. Each resident is assigned a unique User ID and Password for the OB List. The Program Coordinator has the ID/Password for each resident
    b. List access
        i. The list can be accessed via our residency webpage: http://louisville.edu/medschool/familymedicine or accessed directly https://OBList-web.louisville.edu
        ii. It is also saved on the "Favorites" page of many frequently-used computers
    c. Patient Information
        i. Every OB patient should have their information placed on the web-based OB List
        ii. The resident assigned to the patient is responsible for initially entering the patient's information onto the list and periodic upkeep of the patient's information.
        iii. A RESIDENT SEEING THE PATIENT ON ANY GIVEN DAY is responsible for entering any new information onto the list, EVEN IF THE RESIDENT IS NOT THE PATIENT'S ASSIGNED RESIDENT. If a resident sees a patient in triage when on call, signs off on labs for a colleague, delivers the patient, or sees

a patient in clinic, then it is that resident's responsibility to enter any new information on the list.

4. OB chart EHR upkeep
    a. General upkeep
        i. The resident assigned to the patient is primarily responsible for the upkeep of the patient's chart. This includes:
            1. Properly filling out the initial history and physical on the ACOG form
            2. Updating the "problem" list on the ACOG form
            3. Updating the Medicine List on the ACOG form
            4. Updating the Labs on the ACOG form
            5. Keeping Progress Notes in chronological order

5. Delivery Requirements
    a. Total deliveries
        i. Family Practice Residents are expected to perform at least 40 deliveries as the primary physician during their residency. At least 10 of the 40 should be continuity deliveries.
    b. Continuity "Longitudinal" deliveries
        i. Continuity deliveries are comprised of deliveries from the resident's patient panel at their home clinic (assigned during second and third years) and from the TAPP patients assigned during their second year.
        ii. In order for a delivery to qualify as continuity the following apply:
            1. Patient seen prenatally by the assigned resident
            2. Delivery attended by the assigned resident (If the patient has a C-section, the resident should be present for and participate in decision making and immediate postpartum care responsibilities.)
            3. In-hospital postpartum care by assigned resident
            4. Patient seen for at least one postpartum visit by assigned resident
        iii. If you are unsure if a patient qualifies as a continuity delivery or not, please ask the Program Director.
        iv. Continuity deliveries should be recorded as such in New Innovations.

6. OB conferences
    a. General information
    b. OB conferences are held on select Thursdays from 1:00 p.m. to 2:00 p.m. at the Rudd Heart and Lung Center as part of Core Conferences.
    c. "Running the List"
        i. We will "Run the OB List" for the initial 10 minutes of every Thursday's OB conference. This is the time to bring your OB patient questions and interesting cases from the previous week and to pass communication on to your colleagues. This time is often more informative than the formal lecture so please make an effort to be on time and remember to bring your pertinent patient case information with you.

7. Family Medicine/OB resident interaction guidelines on Labor and Delivery
    a. The FM resident will closely and frequently review the care of his or her patient with the 3rd or 4th year OB resident and involve the OB resident in all decisions regarding care of the FM patient, so that the OB residents are fully aware of the status of the FM patient and agree with all care provided to the FM patient by the FM resident.
    b. Concerns should be brought to the OB attending on call.

c. With respect to deliveries, it is to be emphasized that the FM resident is to conduct the delivery and be involved with the delivery (including scrubbing in on cesarean deliveries) to the maximum extent possible for the level of training of the FM resident.
d. OB residents should be involved with the delivery to the same extent that they would be involved with the delivery of OB service patients by junior OB residents. An OB senior resident should be present to assist the FM resident with the delivery.
e. During morning report and evening checkout, the FM resident gives the presentation of the FM patient.
f. When a FM patient presents to OB triage, the FM resident on night float or on call is to be promptly notified. The FM resident is expected to arrive within 30 minutes. If the FM resident does not arrive within this time period or if patient acuity requires immediate care, then the obstetrical team will care for the patient until the FM resident arrives.
g. When a FM resident must leave the L&D area while a FM patient is present, then the FM resident should leave ONLY after checking out with the OB senior resident, and temporarily transferring care to the OB service.

4.3.6 Night Float/On-Call Schedules

The chief resident will make resident assignments for night float and on-call duties. Residents will be notified of a deadline for preferences and a draft of the call schedule will be made and distributed. Once the call schedule has been issued in this form, individual residents are responsible for finding their own replacements, if necessary. These changes should be turned into program staff for amendments to the call schedule before the final print, publication and distribution. The FINAL will be printed and distributed to all faculty and residents. No changes will be made after the final schedule is published. If changes need to be made, the involved physicians must assume the responsibility of notifying the appropriate parties (answering service, hospitals, other residents, etc.) Final schedules are posted in: the Residents Lounge, both FMCs, University Hospital ED, Switchboard, Labor and Delivery, and "Prep" room areas, Jewish Hospital switchboard and ED, Norton's Hospital switchboard and ED, Kosair Children's Hospital switchboard and ED.

4.3.7 Hospital Admissions

4.3.7.1 Admissions from the Office

The procedure for admitting patients to the Family Practice Hospital Service is:

1. Notify the attending or chief resident on the service of an admission and briefly discuss the case.
2. The physician caring for the patient is to write a brief note with a basic assessment and plan. A detailed progress note of the same day may be substituted as an admit note if needed.
   a. Copies of any pertinent diagnostic tests performed at the office or done previously should be included with the admission paper work.
   b. The physician is to write the admitting orders. Make sure the primary team beeper number (455-5895) is included in the orders so that the nursing staff can contact the hospital team once the patient arrives to the floor.
3. Obtain a hospital bed from admitting and verify that a bed is available prior to sending the patient to the hospital.
4. Communication between the hospital service and the admitting physician is crucial if this protocol is to be successful.

ADMISSION ORDERS

University of Louisville Department of Family and Geriatric Medicine

Hospital ______________________ Date / Time _______________________

Patient Name _______________________________ DOB ______________

PCP __________________________ Notified of Admission? _______ Yes ___ No

Full Admit _______ 23 H Observation ________ to U of L Family Medicine,

Attending Dr. __________________________

1. Page 455-5895 **<u>immediately</u>** when patient arrives on floor
2. Condition:
3. Diagnoses:
4. Allergies:
5. Vital signs:
6. Nursing:
7. Diet:
8. Activity:
9. Labs:
10. Special Orders/Tests:
11. Medications:
12. IV:
13. Consults:

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4.3.7.2 Emergency Department Admissions

Sometime a patient calls after office hours and needs to be referred to an emergency room.

Adults:
Three emergency rooms are used: University Hospital, Jewish Hospital, and Kosair's Emergency Departments. Other urgent care centers ("minor emergency rooms") may be allowed by specific insurance plans. Usually, a patient will be sent to the emergency room at the discretion of the resident and based on the particulars of the patient's insurance policy.

> **University Hospital:**
> It is at the discretion of the Family Medicine resident whether Family Medicine or the Emergency Room resident at the University Hospital will see the patient. Whatever the case, the resident should call ahead to the emergency room and inform the staff that a patient has been sent to the emergency room to be seen. That way, the Emergency Room resident will know who to call for follow up.
>
> **Jewish Hospital:**
> The Family Medicine resident who refers a patient to this Emergency Room for evaluation by an emergency room physician must always call the emergency room and inform the emergency room of the referral and provide any pertinent information about the patient that may be helpful to the emergency room physician.
>
> It is at the discretion of the Family Medicine resident whether they or the Emergency Room attending sees the patient. If the resident desires to evaluate a patient in the Emergency Room, they will inform the emergency department of the patient's arrival and stipulate that they will come to the emergency room promptly and that there is no need for the emergency room physician to see the patient.

Pediatric patients:
The resident can send pediatric patients to Kosair Children's Hospital but the resident should call ahead to the emergency room and inform them that they have sent a patient.

If resident desires to evaluate a patient in the Kosair Children's Hospital Emergency Room, they will inform the emergency department of the patient's arrival and stipulate that they will come to the emergency room promptly and that there is no need for the emergency room physician to see the patient.

4.3.8 Patient Care Responsibilities

Care of hospitalized patients must be documented with extreme accuracy. Detailed documentation is required for reimbursement purposes, peer review purposes, and good patient care. This is a serious responsibility and it should not be taken lightly. All entries into the medical record should be entered with the correct date and time and under no circumstances should an entry be post or pre-dated or altered after the fact.

> **University Hospital - Adult Patients:**
>
> Residents should follow these procedures in caring for patients admitted to University of Louisville Hospital:
> At the time of admission, the resident will:

1. Write a brief admitting note and dictate a detailed history and physical,
2. Notify the patient's primary care physician.

The FMHS team will assume responsibility for writing the SOAP note (Subjective Objective Assessment Plans) and progress notes. A progress note should be made in each of the following instances:

1. Any change in the patient's status,
2. Anytime a procedure is performed on a patient,
3. Anytime a major change in the treatment plan for the patient is implemented,
4. Anytime there is a significant abnormal laboratory test of which the resident has been made aware.

Whenever possible the patient's primary provider (resident, faculty or other provider) must visit the patient within 48 hours of admission (72 for a Friday admit) to the hospital and write a brief "PCP" admit note in the patient's chart. The primary provider (continuity resident) and hospital team resident are expected to communicate daily regarding patient problems and progress.

The resident assigned to the patient's care will complete an internal hospital discharge summary to be dispatched to the appropriate follow up dispersement agency *i.e., office site, visiting nurse, or nursing home, etc.*

University Hospital - Obstetric Patients:

Because of the complex nature and potentially serious consequences of adverse outcomes, the documentation of the care provided to obstetrical patients also should be meticulous.

At the time of admission, the resident should enter an admission history and physical into the medical record on the appropriate form on the internet OB list. If the patient is sent to Labor & Delivery before 5:00 p.m., the primary care physician is to call the L & D chief with the patient information, send written orders, and if an admission is anticipated, send a History & Physical in addition to letting them know you will be there as soon as possible. During the patient's labor, the resident should write regular progress notes documenting the patient's progress in labor. Any time an intervention or procedure is performed, a progress note should be written. Whenever the patient's labor deviates from what is expected, the resident should write a progress note. All complications such as fetal heart tone abnormalities rupture of membranes, or any other complication, should be clearly documented in the medical record.

At the time of delivery, the resident should complete the appropriate forms and enter information into the OB on-line list.

When the patient is in the post-partum unit, a progress note should be written daily. Any abnormal laboratory tests should be written into the progress note. Documentation should be provided for any deviation from normal that is observed.

On discharge, the resident should write a discharge note, discharge orders and complete the face sheet according to the routine of the Obstetrical Service. Under no circumstances, should a discharge order be predated. The patient must be seen just before discharge. Do not allow nurses to make a final assessment of the patient before discharge.

The following outlines the agreement between the Department of Family and Geriatric Medicine and the Department of Obstetrics and Gynecology at the University of Louisville.

1. Family Medicine residents evaluate, manage, and deliver continuity patients from both FMCs and the TAPP clinics.

2. Unless otherwise specified, the OB faculty is the scheduled back-up for the Family Medicine resident on call. This faculty is to oversee prep room visits, labor, delivery, and post-partum care. The OB faculty would be the admitting physician to the University of Louisville Hospital for these patients.

    a. The OB faculty may provide direct support to Family Medicine residents through upper level OB residents covering labor and delivery under his or her supervision.

University Hospital - Newborn Nursery:

The post-delivery protocol is as follows:

1. Nursery:
    a. Notify Nursery when the baby arrives that the baby is a Family Medicine patient and give them the attending's name.
    b. Write a brief note on the baby's chart that includes information about the mother and any problems during the pregnancy. Also include a brief summary of the labor and delivery and any complications. Document whether the baby will be bottle or breast fed, and if male, whether he will be circumcised. The initial examination should be a full examination and recorded in the baby's chart.
    c. Call chief of service (either that day or early the next morning) to notify of the delivery and explain any problems.
    d. Make sure you document where and with whom the baby will be following up after discharge.

2. Post-Partum:
    a. OB attendings are currently responsible for signing the mother's chart.
    b. The FM primary physician should write a note on the chart on all post-partum days until the mother is discharged, even if the OB is writing notes and seeing the patient (i.e., C-sections).
    c. Make sure any social problems are addressed and consult a home health service for education if necessary (i.e., young mother).
    d. Document where and with whom the patient will be following up after discharge.

    Daily progress notes should be written in the chart on all newborn patients. Any deviation from normal should be clearly documented. Any time an abnormal laboratory test is returned or an unusual therapeutic move taken, it should be clearly documented in the record. The resident should clearly document all procedures performed on infants also in the record.

    At the time of discharge, the resident physician should perform a discharge examination. Discharge orders also should be written at that time.

University Hospital - Consults:

Family Medicine may be asked to provide a consultation on a patient admitted to another service. Sometimes these patients are Family Medicine patients admitted for a special procedure. At other times, other individuals have cared for these patients and Family Medicine is asked to provide a medical consultation.

The most senior resident on the FMHS team should perform consults. The senior resident should see the patient as soon as possible, usually within four hours. Interns should never be assigned to consults; however the most senior resident may choose to delegate the consult to another upper level resident on the team as needed. The resident assigned to the consult should discuss the case with the FMHS attending as soon as possible - usually, by the end of the working day. It may be possible to wait until the first thing in the morning to have the faculty attending assess the patient for consults obtained during the evening or nighttime hours. However, under emergency situations, coming into the hospital to consult with the senior resident on the patient may be necessary for the faculty attending.

Reports for medical consultations should be written on the appropriate form provided by the hospital. The assessment should be written first, followed by the recommendations. Then the subjective and objective information should be written.

Jewish Hospital

The procedures for caring for a patient at Jewish Hospital are similar to those in caring for an adult hospitalized at University of Louisville Hospital.

Kosair Children's Hospital

The procedures for caring for a patient at Kosair Children's' Hospital are similar to those in caring for an adult hospitalized at University of Louisville Hospital. However, the resident must understand that they are acting as an agent of the attending physician in that instance. All work performed by the resident at Kosair's, which includes admitting notes and orders, must be countersigned by the faculty attending as soon as possible.

4.3.9 Geriatric Hospital Service/Family Medicine Service Policy

The schedule for the Geriatrics team members will be established by the Geriatric Faculty to allow them to provide primary coverage of Geriatric Hospital Service (GHS) patients each weekday from 7:00 a.m. to 5:30 p.m. Cross-coverage of Geriatric hospital patients by the Family Medicine Hospital residents and night float residents (supplemented by the fellows and Geriatric attending when appropriate) will begin at 5:30 p.m. on weekdays and 12:00 noon on weekends/holidays after appropriate check-out procedures have been followed. Official University holidays are: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and the following Friday, and Christmas Day. If the holiday falls on a Saturday, it is observed on Friday. If the holiday falls on a Sunday, it is observed on Monday. This will only occur for Christmas, New Year's Day, and Independence Day. On these occurrences the check-out time is at 3:00 p.m. Election days are not considered holidays.

The procedures for transfer of care are as follows:

The Family Medicine night float or on-call resident will provide call for Geriatric services and for admission of geriatric patients. The Geriatric fellow or attending on-call will provide back-up support services to the resident on call at night. Back-up support services will consist mainly of telephone back-up unless the residents' service capacity is exceeded or the patient is in a critical medical condition and/or being admitted to the intensive care unit at which time the fellow or attending may need to come in to the hospital.

The Geriatric medicine fellow or attending on service (if there is no fellow on service) is responsible for signing out patients who are on the service to the Family Medicine night float or on-call resident at 6:00 p.m. each weekday and 12:00 noon on weekends or holidays. Checkout should be done verbally either in person or by telephone in conjunction with a printed updated daily patient list. The printed list should be posted in the FM call-room in the designated location on the bulletin board. The list should also be e-mailed to the on-call resident. The checkout list should include who is "on-call" for Geriatrics for that night. There should be flexibility and cooperation with the 6:00 p.m. time. There may be instances that the Geriatric day team may need to check out earlier.

All admissions to the Geriatric hospital team prior to 5:30 p.m. will be taken by the Geriatric team. Admissions after 5:30 p.m. will wait for the night float resident unless there is a medical emergency. At that time, the Family Medicine hospital team may need to care for the admission. There should be flexibility and cooperation if there is more than one Geriatric Medicine or Family Medicine hospital admissions between 5:30 p.m. and 6:00 p.m. In this case, either team may need to help with the admissions of their respective services.

Every morning the night float or on-call Family Medicine resident will be responsible for signing out all Geriatric Medicine overnight admissions as well as all called consults (whether seen or not) to the Geriatric Medicine fellow or attending between 7:00-7:15 a.m.

University of Louisville Hospital Admissions:

All established patients from Geriatric Medicine who are admitted to the University of Louisville Hospital will be admitted by the family medicine hospital team. This will not be an open call patient. The geriatric team will be notified of the admission. The family medicine team will decide if geriatrics needs to be consulted for help with the care of the patient.

Procedure if disagreements or questions about the above or about patient care occur:

The Family Medicine resident will call the resident chief of service to discuss the issue. The resident chief of service will contact the Geriatric Medicine fellow. If an agreement cannot be reached, the on-call attending will be consulted.

Procedure to follow if check-out does <u>not</u> occur:

If Geriatric Medicine checkout does not occur by 6:15 p.m., then the Family Medicine resident on call is to call the Geriatric Medicine fellow/attending at 6:15 p.m.

If Family Medicine checkout does not occur by 7:15 a.m., then the Geriatric Medicine fellow is to call the Family Medicine resident at 7:15 a.m.

Revised July 2013

4.3.10 Other Hospitals

The resident should consult the faculty attending anytime a patient is admitted to any other area hospital. The resident should not do negotiations and discussions with outside hospitals. This is a faculty responsibility.

4.3.11 Non-Family Medicine Patients

Occasionally, a physician from the community or out in the state will refer a patient to the Family Medicine Hospital Service for care. Often, these private physicians are former residents of the Family Medicine program. In these cases, the patient will be admitted and cared for in the same way as other Family Medicine patients. The difference is that telephone calls should be made to the private physician to keep them informed of the patient's progress. Most often, the FMHS attending does this. However, when the discharge summary is dictated, the resident must make a notation to have a copy of the discharge summary sent to the private physician out in the city or state.

4.3.12 Transfer of Patients from Other Hospitals

The Family Practice Hospital Service will accept transfers of patients from other hospitals only if the patient is medically stable and free from life-threatening complications. All transfers must be approved by the attending. Anytime a patient is transferred, the attending must be called. Patients coming from either Jewish Medical Center East or Jewish Medical Center South are coming from a Jewish facility and as such should not be considered a transfer, rather, an admission. These patients should be accepted provided that they are medically stable and free from life-threatening complications.

4.3.13 Hospital Census

The FMHS team will admit the first two open-call patient from Jewish Hospital Monday through Friday and the first one on Saturday and Sunday as well as the first two open-call patients from the University Hospital. The FHMS team is to be capped at 20 patients. At this time, there will be no more unassigned admissions until the number of patients is below 20. Established FMC patients are still to be admitted.

4.3.14 Hospital Statistics

The most senior resident will prepare a daily hospital list. Information necessary to meet RRC or Departmental requirements may also be included on it. The Hospital Service team will give this to the departmental staff daily to generate hospital statistics.

4.3.15 Peer Review Actions

Whenever a resident receives written notice from a Peer Review Organization (PRO) about patient care, they should report this to the Program Director.

4.3.16 Billing

Completion of billing is the responsibility of the attending physician.

4.4 Nursing Home Patients

All PGY2 and PGY3 residents are assigned up to five patients at the Sacred Heart Home, 2120 Payne Street, Louisville KY 40206.

Note: Only licensed residents will be assigned nursing home patients. The Geriatric faculty handles assignment of nursing home patients.

4.4.1 Routine Visits and Calls

A resident is routinely assigned a nursing home date, once a month. The program assigns each resident a "regular" nursing home day [NH - one set half day per month (1st, 2nd, 3rd or 4th Thursday morning's beginning at 7:30 a.m.) on the Family Medicine Office Schedules]. It is the resident's responsibility to notify the attending faculty or nurse practitioner if they are not able to go to the nursing home on their regularly scheduled day. This absence is to be made up.

Graduating residents will need to indicate in an order that they are leaving and will no longer be caring for the patient. For example, "After (date) I will no longer be caring for this patient. Dr. (new physician's name) will assume responsibility for the care of (nursing home patient's name)." The new physician will be asked to write an order accepting responsibility for the patient.

4.4.2 Charges

For every visit to the nursing home, the resident must fill out a visit (charge) slip. The resident should turn the visit card into the Geriatric Program Faculty or Nurse Practitioner. There is a time limit for submitting charges to third party payers.

4.5.1 Family Practice Hospital Service Review

1. Three patient topics are selected during their FPHS month by the Hospital Service Chief and placed on a list for potential review. The Chief identifies an issue or question for discussion on each patient.
2. PGY2 and PGY3 residents will sign up to review charts and present them on specific review dates.
    a. **Requirement:** During the academic year (July-June), each PGY2 resident and PGY3 resident will review and present at least 1 chart.
    b. The Chief Residents will coordinate and maintain the review assignment list.
    c. Two residents will each review one patient's chart for presentation on their selected date (a total of two patients will be presented each month).
        i. Patients reviewed will be chosen by the residents from those selected by the Hospital Service Chief in item "1." above.
        ii. A synopsis of the patient reviewed will be presented from a completed one page "FP Hospital Service Monthly Review" form (attached). This completed form should be turned in to the Residency office **before the weekend prior to the presentation date** (so that item "3" below can occur).
        iii. A "Peer Review Form" will also be completed and presented (attached). On this form, a specific question must be formulated to guide the faculty presentation. This may be a brief review of the diagnosis and treatment of an uncommon illness or presentation. It also may be a question regarding a specific treatment or protocol for a more common illness.
3. There will be three parts to the presentation, keeping in mind that each patient presentation/discussion is to last **no more than 25 minutes**.
    a. The residents will present a **5 minute synopsis** of all pertinent points of the case. This is to be concise and specifically review issues identified in the review. The expectation is that this is **NOT** done by PowerPoint, but to emphasize the skill of presenting a complex case in a short amount of time.
    b. A **ten minute discussion** of the case ensues and the group may choose to delve into further details of the case.
    c. A faculty volunteer will present a **concise review** (ten minutes) of the evidence available addressing the interesting issue or question for each patient reviewed. Again, the resident is expected to provide a specific point for review.
4. Patients selected for potential review by a Hospital Service Chief but **NOT** chosen and presented will remain eligible for review in subsequent months, during the current academic year only.

Revised July 2013

FP HOSPITAL SERVICE MONTHLY REVIEW **(Place in Reviewer's Residency file)**

REVIEWER________________________________DATE__________________

Reason for Review:

Patient Identifiers (Age, Sex, Key Descriptors):

Chief Complaint:

History of Present Illness:

Pertinent Past History (Include key medications):

Other Pertinent History (Family, Social, Work, Habits, etc.)

Admission Data (Labs, EKG, Radiology, etc.):

Hospital Course (key elements only):

Ultimate Outcomes/Diagnoses:

Issue/Question for Discussion:

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FAMILY MEDICINE HOSPITAL SERVICE
PEER REVIEW FORM

PATIENT'S NAME & CHART NUMBER	DATE ASSIGNED	DATE RETURNED

Reviewer ____ DATE: ______________________

Attending Physician/Resident: ____

Peer Review Guideline # ______________________ (See back of this form).

PLEASE ANSWER ALL QUESTIONS BY CIRCLING EITHER Y (YES) OR N (NO).
ALL NEGATIVE RESPONSES SHOULD BE EXPLAINED IN THE COMMENT SECTION (BE SPECIFIC).

Y N 1. Length of stay appropriate.

Y N 2. Admission diagnosis correct?

Y N 3. Physician progress notes appropriate?

Y N 4. Final diagnosis supported by evidence?

Y N 5. Special tests/procedures justified?

Y N 6. Therapeutic errors or misadventures?

Y N 7. Consultation rendered promptly?

Y N 8. Interservice problems?

Y N 9. If patient died, was it expected?

Y N 10. If unexpected, is it explained?

COMMENT SECTION: ***EXPLAIN BELOW (BY NUMBER) ANY NEGATIVE RESPONSES.***
BE SPECIFIC IN YOUR RESPONSE.

1. What was done especially well?
2. What could have been done better?
3. Was there anything done wrong?

____

____

____

____

____

Please return completed form to the residency office.

Reviewed July 2013

5.0 American Board of Family Medicine Requirements for Certification

Program Directors are responsible for conducting their residency training programs in compliance with the "Institutional and Program Requirements for Graduate Medical Education in Family Medicine" of the Accreditation Council for Graduate Medical Education (ACGME). Directors should periodically review these requirements with their faculty, staff, and residents.

At the time of entry into a program, the Family Medicine resident is expected to be familiar with: the ACGME "Institutional Requirements", the "Program Requirements for Residency Education in Family Medicine", the "Requirements for Certification by the American Board of Family Medicine", and any additional requirements of the program into which the resident has entered. The ACGME and ABFM requirements are available at their respective websites

It should be noted that any variance from the "Program Requirements for Residency Education in Family Medicine," or failure to comply with the ABFM Requirements for Certification, places the resident at risk of being unable to qualify for the ABFM's examinations.

If there is any doubt regarding compliance with the "Program Requirements for Residency Education in Family Medicine" or ABFM Requirements for Certification, Program Directors are urged to consult with the ACGME and/or the Board.

Selection of Residents

Only those physicians who possess the qualifications set forth in the section on "Eligibility and Selection of Residents" of the ACGME's Institutional Requirements are eligible to enter a Family Medicine residency training program.

Programs must make a special effort to confirm that all of the educational requirements for the M.D. and D.O. degrees have been completed prior to entry for U.S. graduates, and that international graduates have one of the following: a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, a full and unrestricted license to practice medicine in the U.S. licensing jurisdiction in which they are training, or completed a Fifth Pathway program of an LCME-accredited medical school.

The formal registration of all residents in ACGME-accredited Family Medicine residency programs is accomplished via the ABFM's web-based Resident Training Management System. This includes residents who have entered the program as first-year residents, as well as transfers and advanced level placements from other disciplines.

Advanced-Level Entry / Interprogram Transfers:

United States and Canada
Programs seeking to admit a resident into training with credit toward certification for other types of previous accredited training, including training in another ACGME-accredited Family Medicine program, are no longer required to obtain prior approval for transfer/advanced placement of 12 months or less for residents transferring from:

- ACGME-accredited Family Medicine programs
- other ACGME-accredited specialties
- American Osteopathic Association (AOA) approved programs
- Canadian programs approved by the College of Family Physicians of Canada

Transfer/Advanced Placement notification will be facilitated through the online Resident Training Management System. However, some transfer/advanced placement appointments will require **special attention**, requiring **prior approval** from the ABFM. Appointments requiring prior approval include: requests for credit in excess of 12 months, transfers associated with the closing of a program, transfers involving hardship circumstances, and advanced placement for international training.

Transfer/Advanced Placement credit may not exceed 12 months. The amount of credit normally recognized for each curricular area is listed below.

TABLE 1—Maximum Amount of Transfer Credit			
Curricular Area	Credit	Curricular Area	Credit
Human Behavior/Mental Health	2 months	Community Medicine	1 month
Adult Medicine Critical Care (ICU/CCU) Cardiology Women's Health Care of the Older Patient	12 months 1 month 1 month 1 month 1 month	Care of Neonates, Infants Children and Adolescents	4 months
Maternity and Gynecologic Care Maternity Care Gynecologic Care	3 months 2 months 1 month	Diagnostic Imaging and Nuclear Medicine	1 month
General Surgery Genitourinary Disorders Disorders of the Eye, Ear, Nose and Throat	2 months 1 month 1 month	Physical Medicine and Rehabilitation	1 month
Musculoskeletal and Sports Medicine	2 months	Practice Management	1 month
Emergency Care	2 months	Care of the Skin	1 month
Neurology	1 month	Anesthesiology	1 month
Electives	3 months		

If a physician is admitted into training at an advanced level, but the Program Director fails to notify the Board via the Resident Training Management System or other appropriate means prior to the entry of the resident into the program, the Board, at its discretion, may subsequently alter the amount of credit if there is disagreement with the amount or type of credit awarded. Once a resident begins a program at a defined level with a specified amount of credit, no additional credit toward certification for previous training will be authorized.

If it is the intention of the program to use a portion of a resident's previous ACGME, AOA, or College of Family Physicians of Canada (CFPC) -accredited postgraduate education to meet residency program requirements while having the resident complete 36 months of education (e.g., applying the prior training to requirements to permit a greater amount of elective time), the program is NOT required to obtain authorization of credit from the Board.

Should a program recruit a physician for an entry level G-1 position and the physician begins training at that level, the resident will be expected to complete the full residency program of 36 months regardless of the amount of prior training or the performance of the resident after entry.

Transfer from one accredited Family Medicine residency program to another after the beginning of the G-2 year will be considered only when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. **A hardship is defined as a medical condition or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident's family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program.** In considering such transfers, the Board is concerned primarily with the requirements for continuity of care during the resident's second and third years of training as stipulated in the "Program Requirements." All requests must demonstrate the nature and extent of the hardship.

Any change that has not been approved by the Board and is at variance with the requirement for continuity will place the resident's application for the Certification examination in jeopardy.

Advanced-Level Entry/Interprogram Transfers: International
Internationally-trained physicians with postgraduate training outside of the U.S. or Canada may be admitted to an ACGME-accredited Family Medicine program with advanced placement of 12 months or less. However, the program must obtain approval from the American Board of Family Medicine prior to the entry of the resident into training. Please refer to the general details described in the previous section.

Under no circumstances will transfer credit in excess of 12 calendar months be awarded, and such credit, if any, will be restricted to the G-1 year of residency training in Family Medicine. The Board may award credit only for experiences which are equivalent to training in Family Medicine and only in the amount compatible with the "Program Requirements for Graduate Medical Education in Family Medicine."

The physician under consideration must have completed a minimum of three years of international graduate medical education beyond the receipt of the M.D. degree to be considered for any credit.

Requests for transfer/advanced placement credit requiring special attention by the ABFM must include verifiable supporting documentation, including:

- Licensure in the state, province, and/or country of practice
- The medical school diploma (World Health Organization approved)
- Documentation of internship and residency training or equivalent including a description of the clinical rotation schedule or the number of months of specialty training completed
- Specialty and subspecialty certification
- Receipt of a currently valid Standard Certificate from the Educational Commission for Foreign Medical Graduates, or documentation of successful completion of a bona fide Fifth Pathway Program or demonstration of compliance with other ACGME requirements for entry into graduate medical education in the United States

The Board reserves the right to limit the duration of the authorization of credit should the resident fail to enter training at the expected time.

Physicians who are unable to provide all of the necessary documentation of their previous training and fulfill other requirements will be required to complete a full three years of ACGME-accredited residency training in Family Medicine in order to apply for certification.

For information on Part-Time Residency in Family Medicine, Shared Residency, and Double Boarding please go to https://www.theabfm.org/cert/absence.aspx.

Absence from the Residency:

Continuity of Care
The requirements for continuity of care and the Family Medicine Center (FMC) experience are defined by the ACGME in its "Program Requirements for Graduate Medical Education in Family Medicine."

A resident is expected to be assigned to one FMC for all three years, but at least throughout the second and third years of training. The total patient visits in the FMC must be met, and residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training.

Vacation, Illness, and Other Short-Term Absences
Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

The Board recognizes that vacation/leave policies vary from program to program and are the prerogative of the Program Director so long as they do not exceed the Board's time restriction.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually.

Long-Term Absence

Absence from residency education, in excess of one month within the academic year (G-1, G-2 or G-3 year) must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training. Absence from the residency, exclusive of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months in each of the G-2 and G-3 years of training. Leave time may be interspersed throughout the year or taken as a three-month block.
Following a leave of absence of less than three months the resident is expected to return to the program and maintain care of his or her panel of patients for a minimum of two months before any subsequent leave. Leave time must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training. Residents will be permitted to take vacation time immediately prior to or subsequent to a leave of absence.

In cases where a resident is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director is expected to inform the Board promptly by electronic mail of the date of departure and expected return date. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure.

Leaves of absence in **excess** of three months are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.

Waiver of Continuity of Care Requirement for Hardship
While reaffirming the importance of continuity of care in Family Medicine residency training, the Board recognizes that hardships occur in the personal and professional lives of residents. Accordingly, a waiver of the continuity of care requirement or an extension of the leave of absence policy may be granted when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. **A hardship is defined as a debilitating illness or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident's family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program.**

A request for a waiver of the continuity of care requirement or an extension of the leave of absence policy on the basis of hardship must demonstrate:

- that the absence from continuity of care does not exceed 12 months;
- the nature and extent of the hardship;
- that excused absence time (vacation/sick time) permissible by the ABFM and the program for the academic year has been reasonably exhausted by the resident;
- that a medical condition causing absence from training is within the Americans with Disabilities act (ADA) definition of disability.

For absences from training of less than 12 months, the amount of the 24-month continuity of care requirement completed prior to the absence will be considered a significant factor in the consideration of the request.

When the break in continuity exceeds 12 months, it is highly unlikely that waivers of the continuity of care requirement will be granted.

In communicating with the Board, the program should indicate the criteria it will use, if any, to judge the point at which the resident is expected to reenter. The resident may NOT be readmitted to the program at a level beyond that which was attained at the time of departure, but the resident may reenter the program pending a final decision by the Board on the amount of additional training, if any, to be required of the resident.

In-Training Examination

All ACGME-accredited Family Medicine programs are eligible to take the In-Training Examination, which is given annually on the last Friday in October. The purpose of the examination is to provide an assessment of each resident's progress, while also providing programs with comparative data about the program as a whole.

The examination consists of 240 multiple-choice questions and uses a content outline which is identical to the blueprint for the ABFM Certification Examination. ITE examination content is as follows:

In-Training Examination Content		
	Percent	Total
Cardiovascular	12%	29

Endocrine	8%	19
Gastrointestinal	7%	17
Hematologic/Immune	3%	7
Integumentary	6%	14
Musculoskeletal	12%	29
Nephrologic	3%	7
Neurologic	3%	7
Nonspecific	9%	17
Psychogenic	7%	17
Reproductive-Female	4%	10
Reproductive-Male	1%	2
Respiratory	2%	5
Special Sensory	2%	5
Population-based Care This includes topics such as biostatistics and epidemiology, evidence-based medicine, prevention, health policy and legal issues, bioterror, quality improvement, and geographic/urban/rural issues.	5%	12
Patient-based Systems This includes topics such as clinical decision-making, communication and doctor-patient interaction, family and cultural issues, ethics, palliative care, and end-of-life care.	5%	12
Total		240

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The examination includes 4–8 pictorial items, which may be radiographs, EKGs, pictures of dermatologic conditions, or other images. The questions for the examination are written by certified family physicians who may be in either academic medicine or private practice. Before the questions are published, they are reviewed by a committee consisting mostly of current or former residency program directors.

Residents may take the examination in one of two formats: traditional pencil and paper, or over the Internet. The ABFM hopes to expand participation in the Internet-based version during 2011 and 2012 as the examination will be delivered solely via computer over the Internet in 2013.

After the examination is given, residents can download a document from their physician portfolio which contains answers and critiques for all the questions on the exam. These critiques provide a brief rationale for the answer, and also include a recent reference to document the information and provide a source for additional reading.

The examination is scored using statistical analyses similar to those used for the ABFM Certification Examination. One difference, however, is that there is no passing score, since the examination is given to assess progress. Residents consistently show gains each year of their residency, with the biggest gain occurring between years 1 and 2.

Scores are usually available within 6 weeks of the examination date. Program directors can access the scores through the ABFM's Resident Training Management web page. The score reports are nearly identical to those provided to Certification candidates.

5.1 Family Medicine Policy on In-training Exam Remediation

Performance on the In-training Exam correlates well with performance on the In-training Exam correlates well with performance on the ABFM Certification Exam. Low scores also tend to correlate with lower than average knowledge base and/or difficulties with test-taking strategies. The program recognizes that some excellent clinicians do not score highly on their Boards, but it is our goal to train physicians who will become Board Certified in Family Medicine. Therefore the program has adopted the following remediation procedure to identify and provide early educational assistance to residents with low in-training exams based on PGY. For scores lower than the following will require the remediation plan: PGY1 – 350, PGY2 – 410, PGY3 – 450.

1. If history of poor test taking, refer to Educational Consultant.

2. If there is not a history of poor test taking, or if there is a deficit in only one area, consider the problem to be lack of knowledge, and arrange remedial study plan, in the area(s) of deficit.

    a. Specific remediation resources
        i. Core content
        ii. Review books or online materials
        iii. Review past In-training Exams
        iv. Other options, as appropriate, including Board Prep courses before ABFM exams

3. For all residents a remediation plan, with a time frame will be completed and signed by the resident and advisor. There will be at least monthly meeting between the resident and advisor to document progress through the remediation plan.

    a. For PGY2 and 3 the additional requirements will be applied.
    b. No moonlighting will be approved for the academic year until the above steps are satisfactorily completed.
    c. Allowed CME time and dollars must be applied to an AAFP approved “Board Review” course.

Revised July 2013

5.2 Certification MC-FP Exam:

Eligibility Requirements for Certification

Candidates seeking certification must meet the eligibility criteria specified by the American Board of Family Medicine. All primary exams administered by the ABFM are referred to as the Maintenance of Certification (MC-FP) Exam regardless of whether a physician is certifying for the first time or recertifying. In the past, the examination for residents seeking initial certification was administered in July and November/December. In 2012, the summer exam has been moved to April and the fall exam will be administered in November. Other changes implemented with the 2012 exam include the fact that a resident may apply and be permitted to take the examination prior to completion of residency training and prior to obtaining a full and unrestricted medical license. However, all requirements including the medical license and verification of training must be submitted by the final submission deadline in order to obtain certification.

In order to obtain certification candidates must:

1. Successful performance on the ABFM MC-FP Examination
2. The Program Director verifies that the resident has successfully met all of the ACGME program requirements
3. The candidate obtains a currently valid, full, and unrestricted license to practice medicine in the US or Canada

Eligibility Requirements for Initial Certification

All candidates for the American Board of Family Medicine MC-FP Examination for initial certification must have satisfactorily completed three years of training (a full 36 calendar months with 12 months in each of the G-1, G-2, and G-3 years) in a Family Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) subsequent to receipt of the M.D. or D.O. degree from an accredited institution and, when applicable, a Fifth Pathway Year, or receipt of a Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), or compliance with other ACGME requirements for entry into graduate medical training in the United States. If a physician does not meet the eligibility requirements of the ACGME for residency training in Family Medicine, his/her training will not be recognized by the Board.

Candidates who obtained their M.D. degree from medical schools in the United States or Canada must have attended a school accredited by the Liaison Committee on Medical Education or the Committee for Accreditation of Canadian Medical Schools. Candidates who obtained a D.O. degree must have graduated from a college of osteopathic medicine accredited by the American Osteopathic Association.

All applicants for the MC-FP Examination are subject to the approval of the Board, and the final decision regarding any application rests solely with the ABFM. No candidate will be allowed to take the examination until all fees are paid and all requirements have been satisfactorily met.

Satisfactory Completion of Residency

The Board prefers all three years of postgraduate training to be in the same ACGME-accredited Family Medicine program; however, other training may be considered as equivalent (e.g., Flexible/Transitional Year, AOA Osteopathic Internship, etc.). In these cases the American Board of Family Medicine requires residency programs to notify the ABFM of residents who are entering training with Advanced Placement credit via the Resident Training Management (RTM) System. If the Program Director fails to comply, the Board will determine the amount of transfer credit at the time of its discovery of the transfer.

Consequently, the resident may receive less credit toward certification than anticipated and may be required to extend the duration of training.

The last two years of Family Medicine residency training must be completed in the same accredited program. Transfers after the beginning of the G-2 year are approved only in extraordinary circumstances.

All candidates' education and training experiences are subject to review and approval by the ABFM.

Deadline for Completion of Training—Residents who are expected to complete training by June 30 are automatically provided the application link for the April examination. Residents who are expected to complete training between July 1 and October 31 may be declared eligible to apply for the April examination based on a recommendation from their residency program director. Residents who are expected to complete after October 31 and before December 31 will be permitted to apply for the November exam.

Final Verification—Verification of satisfactory completion of residency training is submitted through the Resident Training Management (RTM) system by the Family Medicine Residency Program Director. Program Directors may access the RTM system up to 15 days before the anticipated completion date of the resident to verify satisfactory completion of residency training. Candidates for the Certification Examination will not receive certification until the Program Director has verified this information (pending all other certification requirements have been met). The effective date of certification will be the date in which the physician has met all certification requirements.

Certification will be awarded when all of the criteria are met:

1. Successful performance on the ABFM MC-FP Examination
2. The Program Director verifies that the resident has successfully met all of the ACGME program requirements
3. The candidate obtains a currently valid, full, and unrestricted license to practice medicine in the US or Canada

Continuing Medical Education

Candidates who apply for the Certification Examination within three years of completion of an ACGME-accredited Family Medicine Residency are not required to document any continuing medical education. Candidates who apply after the three-year period will be required to complete the Entry Process, which requires 150 hours of acceptable CME in the last 3 years. Additional information regarding the Entry Process is located below.

Licensure Requirements

To obtain and maintain certification, all candidates must hold a currently valid, full, and unrestricted license to practice medicine in the United States or Canada. Candidates may begin an application and sit for the exam while in the process of obtaining a permanent medical license; however, a permanent license without restrictions or limitations of any kind must be obtained in order to obtain certification (pending all other certification requirements have been met). The effective date of certification will be the date in which the physician has met all certification requirements. Any candidate that sits for the April exam that does not successfully obtain a currently valid, full, and unrestricted license to practice medicine in the United States or Canada by December 31 of that year will have their exam invalidated with no refund of the exam fee. Any candidate who sits for the November exam must obtain a currently valid, full and unrestricted license to practice medicine in the United States or Canada by June 30 the following year or have their exam invalidated with no refund of the exam fee. In all cases, the candidate will be responsible for the full exam fee for any subsequent examination.

Any action (including "Non-Disciplinary" actions and/or actions against a temporary or training/educational license) by a licensing authority potentially places a physician in jeopardy of losing Diplomate status and/or eligibility for certification. If a physician is uncertain about the status of a medical license relative to ABFM policy, a written inquiry should be made to the Board prior to attempting an application. A violation of ABFM policy on licensure can be any action by a state licensing agency, agreement between a licensing agency and a physician, or voluntary action by a physician that revokes, restricts or suspends the physician's medical license (including any actions against an institutional, temporary, and training medical licenses). In cases where a physician has changed his/her residence deliberately to avoid prosecution, loss of license, or disciplinary action by a state licensing agency, the Board reserves the right to revoke or suspend Diplomat status and/or prohibit application for certification. Unrestricted licenses that have become inactive (e.g. expired, nonrenewal) are not a violation of the Board's policy on licensure, as long as the physician maintains at least one other current, full, valid, and unrestricted medical license in the U.S. or Canada. Furthermore, every license to practice medicine held by the candidate in any state or territory of the United States or province of Canada must be currently valid, full, and unrestricted whether or not the candidate in effect practices in such state, territory, or province. Candidates shall be required to maintain a full and unrestricted medical license in the United States or Canada even if a physician is out of the country for extended periods of time.

Any candidate whose license to practice medicine has been revoked, restricted, or suspended in ANY state or territory of the United States or province of Canada shall be ineligible for certification until such time as the encumbered license is reinstated in full. Should a license be revoked, restricted, or suspended following the submission of an application for certification but prior to the notification of examination results, the application and certification will be simultaneously invalidated.

It is the responsibility of the candidate to inform the Board in writing immediately upon a change in licensure status. Candidates should be aware that the ABFM receives periodic Disciplinary Action Reports from the American Medical Association of actions by states against medical licenses.

MC-FP Entry Process
Any physician who does not successfully pass the MC-FP examination within three calendar years following the year in which residency training is completed will be required to satisfy the MC-FP Entry Process in order to be eligible for the exam and gain certification status.

The MC-FP Entry Process includes:

- Completion of fifty (50) MC-FP points including at least one SAM and one approved Part IV activity
- Completion of one hundred fifty (150) credits of acceptable continuing medical education
- Three (3) MC-FP Process Payments
- Submission of an application for the examination with full payment of the examination fee

For complete information on Maintenance of Certification please go to: https://www.theabfm.org/moc/part3.aspx.

5.3 Types of Licenses

It is the policy of the Board that a physician who has completed two or more years of accredited training and passed all components of a Board approved licensing examination must apply for a Regular license in the state of Kentucky.

Physicians in their first year of post graduate training (PGY1) are exempt from licensure pursuant to KRS 311.560, section 2(c). After completion of one year of training, a physician is required to obtain an Institutional Practice Limited License or a Residency Training License to practice in Kentucky.

Regular License

A Regular License is issued to a physician who meets statutory and regulatory requirements for licensure. All graduates must complete two years of ACGME accredited postgraduate training. Successful completion of a Board approved licensing examination is also required for licensure. Please refer to 311.571, 201 KAR 9:021 and 201 KAR 9:031 .

Institutional Practice Limited License

An Institutional Practice Limited License (IP) is issued to a physician entering an ACGME residency training in program Kentucky. This license limits medical practice to the parameters of a training program. This license is issued on an academic calendar year, July 1 to June 30, and renewable annually while in training. An applicant must have completed one year of ACGME accredited postgraduate training and Parts 1 and 2 of the USMLE or COMLEX. Please refer to 311.571.

Residency Training License

It is the policy of the Board that a physician who has completed two or more years of accredited training and passed all components of a Board approved licensing examination must apply for a Regular license in the state of Kentucky.

A Residency Training License (R) is issued to a physician entering residency training in Kentucky. This license allows a physician to practice within the parameters of the training program, as well as moonlight at locations designated by the Program Director. This license allows a physician to apply for a DEA license. This license is issued on an academic year, July 1 to June 30, and is renewable annually while in training. An applicant must have completed one year of ACGME accredited postgraduate training and all parts of the USMLE or COMLEX. Please refer to 311.571.

Below is information on Kentucky laws as well as websites that residents should become familiar.

Reportable Diseases – Please refer to:

http://chfs.ky.gov/nr/rdonlyres/9ae49c9e-fb77-4158-b226-c8b2f149f3d5/15202/kentuckyreportablediseaseform2003.pdf

Kentucky Medical Practice Act - Statutes & Regulations – Please refer to:

http://kbml.ky.gov/board/laws.htm

Child Abuse

From time to time a resident will be called to see a child in the office or the emergency room who may have been battered. Kentucky State Law **requires** physicians to report any cases of SUSPECTED abuse to the Child Abuse Hotline (Jefferson County – 595-4550).

72-HOUR HOLD BY PHYSICIANS AND HOSPITAL ADMINISTRATORS

Although medical personnel may not take children into protective custody, they do have the right to hold a child whom they feel is in imminent danger.

KRS 620.040(5)(b) states:

If a child who is in the hospital or under the immediate care of a physician appears to be in imminent danger if he is returned to the persons having custody of him, the physician or hospital administrator may hold a child without court order provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed seventy-two (72) hours.

For more information please refer to the child abuse and neglect booklet at:

http://chfs.ky.gov/nr/rdonlyres/0984fd14-a494-4055-9c10-98cdd433f8c9/0/childabuseandneglectbooklet.pdf

Spouse Abuse

All known or suspected incidents of domestic violence/spouse/partner abuse or neglect are to be reported to the Cabinet for Health and Family Services (CHFS) pursuant to KRS 209A.030.

For more information please refer to:

http://manuals.sp.chfs.ky.gov/chapter21/Pages/211IntroductiontoReportofDomesticViolenceSpousePartnerAbuseorNeglect.aspx